CIGNA HealthCare

CIGNA HealthCare of Arizona, Inc.

Point of Service

This document explains your Point-of-Service product. Your in-network benefits are provided by CIGNA HealthCare of Arizona, Inc. and are explained in the Group Service Agreement portion of this document. Your out-of-network benefits are provided by Connecticut General Life Insurance Company and are explained in the Out-of-Network portion of this document.

This document takes the place of any documents previously issued to you which described your benefits.

Thank you for choosing CIGNA HealthCare!

Here is your guide to getting the most from your health care plan.

It outlines the important benefits of belonging to a CIGNA HealthCare plan,

tells you how to use those benefits wisely and

should answer most of your questions.

Please keep it for reference.

If you can't find the information that you need,

call Member Services at

the toll-free number on your CIGNA HealthCare ID card.

Or visit our web site, www.cigna.com.

We're here to help!

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CIGNA HealthCare Point-of-Service Handbook

The Benefits of Belonging to a CIGNA HealthCare Plan

Your CIGNA HealthCare plan is designed to help you stay healthy.

As you read through this information, you'll learn more about the covered services, benefits and special programs that help you take better care of yourself.

You choose a Primary Care Physician (PCP) to serve as your personal physician. Each covered member of your family can choose his or her own PCP.

Your plan includes:

- Preventive Care – coverage for regular checkups, tests and childhood immunizations when your PCP coordinates your care.
- As part of CIGNA HealthCare's commitment to women's health, you can see an OB/GYN in the CIGNA HealthCare network for covered obstetrical and gynecological services without a referral from your PCP.
- Prenatal care once your pregnancy is confirmed. When you see a participating OB/GYN, you pay only the copayment for the first office visit, the one that confirms you're pregnant. After that, you pay nothing for routine maternity office visits throughout your pregnancy.
- 24-hour emergency coverage, worldwide.
- **Access to the CIGNA HealthCare 24-Hour Health Information Line.**SM This line is staffed by Registered Nurses who can assist with health related questions at any time of the day or night. Look for the 24-Hour Health Information Line Library at the end of this guide.
- **Guest Privileges** – under certain circumstances, such as when you are temporarily away from your usual service area for at least 60 days, you may be able to obtain coverage in another area where there is a CIGNA HealthCare plan available.
- **Working Wonders**® to reward you for staying fit and active. Just call 1.800.811.1872 to learn more about the program.
- **CIGNA HealthCare *Healthy Rewards***®, the CIGNA HealthCare program that gives you special offers for discounts on health-related products and services. To learn more, call 1.800.870.3470 or visit our Web site at www.cigna.com.

How Your Point-of-Service (POS) Plan Works

A Point-of-Service plan gives you important options. Each time you need care, you can choose the providers and the level of coverage that work best for you in that situation.

When Your PCP Coordinates Your Care

Your PCP can treat you for a wide variety of conditions, provide important preventive care checkups and tests, and refer you to participating providers and facilities for care at the lowest out-of-pocket cost.

When you see your PCP first, you pay only a copayment for office visits. Your out-of-pocket costs for hospital and outpatient care are lowest. Authorization is necessary for hospitalizations and some types of outpatient care. But there's no paperwork for you. Your PCP handles everything.

When Your Care is Not Coordinated by Your PCP

When you receive care from a provider who is not in the network, or you receive care from any provider without first getting a referral from your PCP, your out-of-pocket costs will be higher. Some services may not be covered.

You are responsible for all authorizations, and you'll pay for your care and file a claim. Claim forms are available from your employer or Member Services.

Your plan also requires you to meet an annual deductible. Until you meet your plan's deductible amount, you pay the entire cost of any care you receive. Once you reach this amount, your coverage begins and you pay a percentage of the cost of your care.

Services you receive are covered only up to your plan's "reasonable and customary" amounts. You pay any charges above your plan's reasonable and customary maximums.

You, not your doctor, are responsible for receiving authorization in advance for all non-emergency hospital stays, outpatient surgeries and major diagnostic tests, including MRIs. If you do not receive prior authorization, your coverage will be reduced. To get the necessary authorization:

- Call Member Services at the toll-free number on your CIGNA HealthCare ID card 14 days before a scheduled admission, or as soon as possible.
- If we have questions about your stay, we will discuss the details with your doctor and reach an agreement regarding appropriate, covered hospital services.
- Your plan will not cover charges for stays longer than the approved length.
- You do not need authorization for maternity stays of 48 hours for vaginal deliveries or 96 hours for Cesarean section. Longer stays must be authorized by CIGNA HealthCare.

When you submit your claim, if there is balance remaining after your plan has paid its share of the cost, you'll receive an Explanation of Benefits (EOB). It will show the charges for your care, how your out-of-pocket payments are accumulating toward your deductible, the amount your plan has paid and the unpaid amount for which the provider will bill you. Wait for your EOB before paying any bills related to your claim. If you receive a bill that does not agree with your EOB, or if you believe that you are being billed for a charge that should be covered by your plan, call Member Services.

GETTING THE MOST FROM YOUR PLAN

- *The best way to control your costs, and get the most from your CIGNA HealthCare network, is to start with your PCP. He or she will provide primary care and can refer you to a wide variety of participating specialists and facilities that meet CIGNA HealthCare quality standards.*
- *If you go to a doctor or facility without first getting a referral from your PCP, your costs will be higher. But you can control those costs by choosing doctors and facilities that participate in the CIGNA HealthCare network. They have agreed to charge lower, negotiated fees for covered services provided to CIGNA HealthCare participants. In any case, you should check your plan materials or call Member Services in advance to verify that the services are covered.*
- *Your PCP will obtain any authorization that is needed for in-network outpatient or inpatient hospital care. You can always call Member Services to confirm that the authorization is complete.*
- *If you have any questions about your plan and coverage, refer to your plan materials, call Member Services toll-free, or visit our Web site, www.cigna.com.*

If You Have a Question

This Handbook briefly summarizes some of the important features of your coverage. For a complete explanation of your coverage please refer to your Group Service Agreement and Certificate.

Where to Find More Information

CIGNA HealthCare offers you a variety of ways to learn more about your plan and coverage. We strive to make sure that the answers you need are always close by.

Your CIGNA HealthCare ID Card

Your CIGNA HealthCare identification (ID) card identifies you as a CIGNA HealthCare member to physicians, hospitals and other health care providers. Show it and you'll receive all of the service and supplies your plan offers as long as you are eligible.

- Carry it with you at all times.
- Show it whenever you receive medical care.
- If you lose your card or if it's stolen, just call 1-800-CIGNA24. We'll send you a replacement right away.
- Each family member covered by your plan, even your children, should have his or her own card. If you need additional cards for family members, just call Member Services.

Member Services

Member Services answers your questions, finds the information you need and works to resolve your problem quickly.

- The toll-free number is on your CIGNA HealthCare ID card.
- Se habla Español – and most other languages. We have bilingual representatives in Spanish-speaking areas and the AT&T Language Line translates more than 140 other languages.

Call Member Services if:

- Any of your personal or family information changes – name, address, phone number, marital status, employment or number of dependents. Also notify your employer of these changes.
- You have questions about how your plan works, your benefits, or a claim.
- You'd like an updated Physician Directory or more detailed information about a doctor or hospital.
- You want to change your PCP.

www.cigna.com

Our interactive web site is a valuable source of information. We update it often, so visit it often! You can:

- Find participating physicians, specialists, hospitals, and pharmacies fast. Now available in most areas, our interactive directories do the work. You can also download and print customized directories, even change your PCP online.
- Learn more about your plan and the benefits and programs available to you and your covered family members.
- Visit ***YourHealth@CIGNA***® to learn about important health care topics. Read online editions of our newsletter for helpful information on personal and family health, diet, exercise and healthy lifestyles.

The CIGNA HealthCare 24-Hour Health Information LineSM

No matter where in the U.S. you are, helpful health information is as close as the nearest phone. Just call the CIGNA HealthCare 24-Hour Health Information Line[SM]. The toll-free number is 1.800.564.8982. You can:

- Speak with registered nurses for answers to your health questions, including questions regarding emergency or urgent care, and get self-care tips that can help ease the discomfort of an illness or injury.
- Listen to informative, recorded programs on more than 1,000 health topics. The Health Information Library program list is at the end of this guide.
- Listen to as many programs as you like, whenever you like. And you can control all of the playback functions with your phone.

This service is available around the clock, seven days a week.

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Emergencies

An emergency is a sudden unexpected injury or a serious illness that a prudent layperson (a person with an average knowledge of medical science) believes needs to be treated right away or it could result in loss of life, serious medical complications or permanent impairment. For

more information about emergency care, please see "Section IV" in the Group Service Agreement.

What to do in an emergency:

- Don't delay! Get help immediately. Call or ask someone to call 911 or your local emergency service, police or fire department. Or go directly to the nearest emergency facility.
- In an emergency you can go to any emergency facility or hospital, anywhere, even one that is not in the CIGNA HealthCare network.
- You do not need a referral from your PCP for emergency services, but you do need to call your PCP as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP will coordinate it and handle the necessary authorizations for care or hospitalization.
- You're covered 24 hours a day, seven days a week.
- You will pay only a copayment for covered emergency services; it may be higher than your office visit copayment and it's listed on your CIGNA HealthCare ID card.
- If you are unsure about whether you should seek emergency care you can call your PCP, the physician covering calls for your PCP or the CIGNA HealthCare 24-Hour Health Information Line.SM

Examples of emergency situations can include:

- Uncontrolled bleeding
- Seizure or loss of consciousness
- Shortness of breath
- Chest pain or severe squeezing sensation in the chest
- Suspected overdose of medication or poisoning
- Sudden paralysis or slurred speech
- Burns
- Cuts
- Broken bones

Urgent Care

You're also covered for situations that aren't emergencies but still require prompt medical attention. Examples can include:

- Severe sore throat
- Sprains and strains
- Ear or eye infection
- Fever in an adult or child

What to do when you need urgent care:

- If possible, call your PCP first. This notifies your doctor of your condition and helps coordinate your care for effective treatment.
- You can also call the CIGNA HealthCare 24-Hour Health Information Line[SM] and ask to speak with a registered nurse about your condition.

Your PCP or the CIGNA HealthCare 24-Hour Health Information Line nurse may recommend steps you can take to be more comfortable and/or schedule an office visit.

Other Medical Care

Situations that are not considered emergencies or do not require urgent care should be handled through a scheduled office visit with your PCP. Examples can include:

- Routine physicals
- Childhood immunizations
- Routine care for chronic conditions
- Follow-up visits to check injuries or broken bones
- Prescription drug needs

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Advance Directives

Your Right to Make Health Care Decisions Under the Law in Arizona

The following explains your right to make health care decisions and explains how "Advance Directives" can help you plan what medical care you want when you are unable to express your wishes.

We hope that what you read here will help you understand how you can increase your control over your medical treatment.

This information is sent to all adult members of CIGNA HealthCare in compliance with the Patient Self-Determination Act (PSDA) of 1990 enacted by Congress and effective December 1991. It is part of CIGNA's ongoing community education on health care and member's rights.

If you have any questions about material in this brochure, it is suggested that you discuss them with your physician, medical social worker, or call CIGNA HealthCare's Member Services Department.

Arizona and federal law give every competent adult, 18 years or older, the right to make their own health care decisions, including the right to decide what medical care or treatment to accept, reject or discontinue. If you do not want to receive certain types of treatment or you wish to name someone to make health care decisions for you, you have the right to make these desires known to your doctor, hospital or other health care providers, and in general, have these rights respected. You also have the right to be told about the nature of your illness in terms that you can understand, the general nature of the proposed treatments, the risks of failing to undergo these treatments and any alternative treatments or procedures that may be available to you.

However, there may be times when you cannot make your wishes known to your doctor or other health care providers. For example, if you were taken to a hospital in a coma, would you want the hospital's medical staff to know what your specific wishes are about the medical care that you want or do not want to receive.

The following describes what Arizona and federal law have to say about your rights to inform your health care providers about medical care and treatment you want, or do not want, and about your right to select another person to make these decisions for you, if you are physically or mentally unable to make them yourself.

To make these difficult issues easier to understand, we have presented the information in the form of questions and answers. Because this is an important matter, we urge you to talk to your spouse, family, close friends, personal advisor, your doctor and your attorney before deciding whether or not you want an advance directive.

General Information About Advance Directives

Q. What are "Advance Directives"?

A. Advance directives are documents which state your choices about medical treatment or name someone to make decisions about your medical treatment, if you are unable to make these decisions or choices yourself. They are called "advance" directives, because they are signed in advance to let your doctor and other health care providers know your wishes concerning medical treatment. Through advance directives, you can make legally valid decisions about your future medical care.

Arizona law recognizes 4 types of advance directives:

1) A Living Will.
2) A Health Care Power of Attorney.
3) A Mental Health Care Power of Attorney.
4) A Pre-hospital Medical Care Directive.

Q. Do I have to have an Advance Directive?

A. No, it is entirely up to you whether you want to prepare any documents. But if questions arise about the kind of medical treatment that you want or do not want, advance directives may help to solve these important issues. Your doctor or any health care provider cannot require you to have an advance directive in order to receive care; nor can they prohibit you from having an advance directive. Moreover, under Arizona law, no health care provider or insurer can charge a different fee or rate depending on whether or not you have executed an advance directive.

Q. What will happen if I do not make an Advance Directive?

A. You will receive medical care even if you do not have any advance directives. However, there is a greater chance that you will receive more treatment or more procedures than you may want.

If you cannot speak for yourself and you do not have any advance directives, your doctor or other health care providers will look to the following people in the order listed for decisions about your care:

1) Your guardian, if a court has appointed one, who is authorized to make health care decisions for you;
2) Your spouse;
3) An adult child, or if you have more than one adult child, a majority of those children who are reasonably available for consultation;
4) Either of your parents;
5) Your domestic partner, if you are unmarried and no other person has assumed financial responsibility for you;
6) An adult brother or sister, or if you have more than one, a majority of those who are reasonably available for consultation;
7) A close friend of yours.

Q. How do I know what treatment I want?

A. Your doctor must inform you about your medical condition and what different treatments can do for you. Many treatments have serious side effects. Your doctor must give you information, in language that you can understand, about serious problems that medical treatment is likely to cause. Often, more than one treatment might help you and different people might have different ideas on which is best.

Your doctor can tell you the treatments that are available to you, but he cannot choose for you. That choice depends on what is important to you.

Q. Whom should I talk to about Advance Directives?

A. Before writing down your instructions, you should talk to those people closest to you and who are concerned about your care and feelings. Discuss them with your family, your doctor, friends and other appropriate people, such as a member of your clergy or your lawyer. These are the people who will be involved with your health care, if you are unable to make your own decisions.

Q. When do Advance Directives go into effect?

A. It is important to remember that these directives only take effect when you can no longer make your own health care decisions. As long as you are able to give "informed consent," your health care providers will rely on YOU and NOT on your advance directives.

Q. What is "Informed Consent"?

A. Informed consent means that you are able to understand the nature, extent and probable consequences of proposed medical treatments and you are able to make rational evaluations of the risks and benefits of those treatments as compared with the risks and benefits of alternate procedures AND you are able to communicate that understanding in any way.

Q. How will health care providers know if I have any Advance Directives?

A. All hospitals, nursing homes, home health agencies, HMOs and all other health care facilities that accept federal funds must ask if you have an advance directive, and if so, they must see that it is made part of your medical records.

Q. Will my Advance Directives be followed?

A. Generally, yes, if they comply with Arizona law. Federal law requires your health care providers to give you their written policies concerning advance directives. A summary statement of those policies is provided for you at the back of this book. It may happen that your doctor or other health care provider cannot or will not follow your advance directives for moral, religious or professional reasons, even though they comply with Arizona law. If this happens, they must immediately tell you. Then they must help you transfer to another doctor or facility that will do what you want.

Q. Can I change my mind after I write an Advance Directive?

A. Yes, at any time, you can cancel or change any advance directive that you have written. To cancel your directive, simply destroy the original document and tell your family, friends, doctor and anyone else who has copies that you have cancelled them. To change your advance directives, simply write and date a new one. Again, give copies of your revised documents to all the appropriate parties, including your doctor.

Q. Do I need a lawyer to help me make an Advance Directive?

A. A lawyer may be helpful and you might choose to discuss these matters with him, but there is no legal requirement in Arizona to do so.

Q. Will my Arizona Advance Directive(s) be honored in another state?

A. The laws on advance directives differ from state to state, so it is unclear whether an Arizona advance directive will be honored in another state. Because an advance directive is a clear expression of your wishes about medical care, it will influence that care no matter where you are admitted. However, if you plan to spend a great deal of time in another state, you should consider signing an advance directive that meets all the legal requirements of that state.

Q. Will an Advance Directive from another state be honored in Arizona?

A. Yes. An advance directive executed in compliance with another state's laws will be honored in Arizona to the extent permitted by Arizona law.

Q. What should I do with my Advance Directives?

A. You should keep them in a safe place where your family members can get to them. Do NOT keep the original copies in your safe deposit box. Give copies of these documents to as many of the following people as you are comfortable with: your spouse and other family members; your doctor; your lawyer; your clergy person; and any local hospital or nursing home where you may be residing. Another idea is to keep a wallet card in your purse or wallet which states that you have an advance directive and who should be contacted.

Living Will

Q. What is a "Living Will"?

A. A living will is a document which tells your doctor or other health care providers whether or not you want life-sustaining treatments or procedures administered to you if you are in a terminal condition or if you are in a persistent vegetative state. It is called a "living will" because it takes effect while you are still living.

Q. Is a "Living Will" the same as a "Will" or "Living Trust"?

A. No. Wills and living trusts are financial documents which allow you to plan for the

distribution of your financial assets and property after your death. A living will only deals with medical issues while you are still living. Wills and living trusts are complex legal documents and you usually need legal advice to execute them. You do not need a lawyer to complete your Arizona living will.

Q. When does an Arizona Living Will go into effect?

A. An Arizona living will goes into effect when:

1) Your doctor has a copy of it, and
2) Your doctor has concluded that you are able to make your own health care decisions, and
3) Your doctor has determined that you are terminally ill or that you in a persistent vegetative state.

Q. What are "life-sustaining" treatments?

A. These are treatments or procedures that are not expected to cure your terminal condition or make you better. They only prolong dying. Examples are mechanical respirators which help you breathe, kidney dialysis which clears your body of wastes, and cardiopulmonary resuscitation (CPR) which restores your heartbeat.

Q. What is a "terminal" condition?

A. A terminal condition is defined as an incurable condition for which administration of medical treatment will only prolong the dying process and without administration of these treatments or procedures, death will occur in a relatively short period of time.

Q. What is a "persistent vegetative" state?

A. A persistent vegetative state means that a patient is in a permanent coma or state of unconsciousness caused by illness, injury or disease. The patient is totally unaware of himself, his surroundings and environment, and to a reasonable degree of medical certainty, there can be no recovery.

Q. Is a Living Will the same as a "Do Not Resuscitate (DNR)" order?

A. No. An Arizona living will covers almost all types of life-sustaining treatments and procedures. A "Do Not Resuscitate" order covers two types of life-threatening situations. A DNR order is a document prepared by your doctor at your direction and placed in your medical records. It states that if you suffer cardiac arrest (your heart stops beating) or respiratory arrest (you stop breathing), your health care providers are not to try to revive you by any means.

Q. Will I receive medication for pain?

A. Unless you state otherwise in the living will, medication for pain will be provided where appropriate to make you comfortable and will not be discontinued.

Q. Can my doctor be sued or prosecuted for carrying out the provisions of an Arizona Living Will?

A. No. The Arizona Living Wills and Health Care Directives Act states that any health care provider who makes good faith decisions based on an apparently genuine health care directive is immune from criminal and civil liability and is not subject to any professional discipline.

Q. Does a Arizona Living Will affect insurance?

A. No. The making of a living will, in accordance with Arizona law, will not affect the sale or issuance of any life insurance policy, nor shall it invalidate or change the terms of any insurance policy. In addition, the removal of life-support systems according to Arizona law, shall not, for any purpose, constitute suicide, homicide or euthanasia, nor shall it be deemed the cause of death for the purposes of insurance coverage.

Q. Does an Arizona Living Will have to be signed and witnessed?

A. Yes, you must sign (or have someone sign the document in your presence and at your

direction, if you are unable to sign) and date the living will. Then it must be witnessed by 1 or 2 qualified adult people or notarized.

1) If you are able to have 2 witnesses sign the living will, neither of them may be your treating health care provider or an employee of your treating health care provider.
2) If only one witness signs the living will, he/she may not be your treating healthcare provider, an employee of your treating health care provider, related to you by blood, marriage or adoption, or entitled to any part of your estate upon your death.

Health Care Power of Attorney

Q. What is a Health Care Power of Attorney? (HPOA)

A. A HPOA is a legal document which allows you (the "principal") to appoint another person (the "attorney-in-fact" or "agent") to make medical decisions for you if you should become temporarily or permanently unable to make those decisions yourself. The person you choose as your attorney-in-fact does not have to be a lawyer.

Q. Who can I select to be my Agent?

A. You can appoint almost any adult to be your agent. You should select a person(s) knowledgeable about your wishes, values, religious beliefs, in whom you have trust and confidence, and who knows how you feel about health care. You should discuss the matter with the person(s) you have chosen and make sure that they understand and agree to accept the responsibility.

Members of your family, such as your spouse, child, brother or sister, or even a close friend are usually good choices to be your agent.

Arizona law does not place any restrictions on who you can appoint as your agent. However, it is usually not a good idea to appoint your treating doctor, his/her employees, the owner or operator of a health care facility in which you are a resident or any of his or her employees. This is due to a possible conflict of interest between being your agent and having a direct bearing on the kind of health care you will or will not receive.

Q. When does the HPOA take effect?

A. The HPOA only becomes effective when you are temporarily or permanently unable to make your own health care decisions and your agent consents to start making your decisions. Your agent will begin making decisions after your doctors have decided that you are no longer able to make them. Remember, as long as you are able to make treatment decisions, you have the right to do so.

Q. What decisions can my Agent make?

A. Unless you limit his/her authority in the HPOA, your agent will be able to make almost every treatment decision in accordance with accepted medical practice that you could make, if you were able to do so. If your wishes are not known or cannot be determined, your agent has the duty to act in your best interest in the performance of his/her duties. These decisions can include authorizing, refusing or withdrawing treatment, even if it means that you will die. As you can see, the appointment of an agent is a very serious decision on your part.

Q. Can there be more than one Agent?

A. Yes. While you are not required to do so, you may designate alternates who may also act for you, if your primary agent is unavailable, unable or unwilling to act. Your alternates have the same decision-making powers as the primary agent.

Q. Does the HPOA have to be signed and witnessed?

A. Yes, you must sign (or have someone sign the HPOA in your presence and at your direction, if you are unable to sign) and date it. Then it must be witnessed by 1 or 2 qualified adults or notarized.

1) If you are able to have 2 witnesses sign the HPOA, neither of them may be the agent(s) that you appointed in the HPOA, your treating health care provider, or an employee of your treating health care provider.
2) If only one witness signs the HPOA, he/she may not be the agent(s) you appointed in the HPOA, your treating health care provider, an employee of your treating health care provider, related to you by blood, marriage or adoption, or be entitled to any part of your estate upon your death.

Mental Health Care Power of Attorney

Q. What is a Mental Health Care Power of Attorney (MHCPA)?

A. A MHCPA is a legal document which allows you (the "principal") to appoint another person (the "attorney-in-fact" or "agent") to make mental health care decisions for you, if you are no longer able to make those decisions yourself. It is very similar to the HPOA, but the MHCPA ONLY deals with mental health care.

Q. When does the MHCPA take effect?

A. The MHCPA only becomes effective when you are temporarily or permanently unable to make your own mental health care decisions and your agent consents to start making your decisions. Your agent will begin making decisions after your doctors have decided that you are no longer able to make them. Remember, as long as you are able to make mental health care decisions, you have the right to do so.

Q. Who can I select to be my Agent?

A. You can appoint almost any adult person to be your agent. You should select a person knowledgeable about your wishes, values, religious beliefs, in whom you have trust and confidence, and who knows how you feel about mental health care. You should discuss the matter with the person(s) you have chosen and make sure that they understand and agree to accept the responsibility.

Members of your family, such as your spouse, child, brother or sister, or even a close friend are usually good choices to be your agent.

The only person who CANNOT be appointed as your agent in the MHCPA is anyone who is directly involved with the provision of health care to you (i.e. your doctor or an administrator of a health care facility in which you are residing).

Q. Where can I get the MHCPA form?

A. You should contact your doctor or other health care provider to get a copy of the suggested document, or you can send $2.00 and a self addressed envelope to Professional Media Resources, P.O. Box 460380, St. Louis, MO 63146 and the document (available in English only) will be mailed to you.

Q. Does the MHCPA have to be signed and witnessed?

A. Yes, you must sign (or have someone sign the MHCPA in your presence and at your direction, if you are unable to sign) and date it. Then it must be witnessed by 1 or 2 qualified adults or notarized.

The following people CANNOT witness your signature of the MHCPA:

1) If you are able to have 2 witnesses sign the MHCPA, neither of them may be a person able to make medical decisions on your behalf or a professional care provider directly involved with the provision of care to you.
2) If only 1 witness signs the MCHPA, he or she may not be a person able to make medical decisions on your behalf, a professional care provider directly involved with the provision of care to you; related to you by blood, marriage or adoption, or be entitled to any part of your estate upon your death.

Prehospital Medical Care Directive

Q. What is a "Pre-hospital Medical Care Directive?

A. A Pre-hospital Medical Care Directive is a document prepared by you to tell emergency personnel that you do not want cardiopulmonary resuscitation (CPR) performed should you suffer cardiac or respiratory arrest in an emergency situation or in an emergency room.

Q. Does the Directive have to be signed and witnessed?

A. Yes, you must sign (or have someone sign the document in your presence and at your direction, if you are unable to sign) and date it. Then it must be witnessed by one individual AND signed by your doctor.

Q. Where can I get the Pre-hospital Medical Care Directive Form?

A. You should contact your doctor or other health care provider to get a copy of the suggested document, or you can send $1.00 and a self addressed envelope to Professional Media Resources, P.O. Box 460380, St. Louis, MO 63146 and the document (available in English only) will be mailed to you.

CIGNA HealthCare of Arizona, Inc. Policy on Advance Directives

CIGNA HealthCare of Arizona has a policy that complies with Arizona laws and court decisions on Advance Directives. CIGNA HealthCare is here to assist you in making these difficult decisions by supplying you with information to help you become an informed partner in your health care team.

CIGNA HealthCare shall document in your medical record whether or not you have executed an Advance Directive. For purposes of this policy, an Advance Directive means a written instruction that relates to the provision of health care when you are incapacitated, such as Durable Power of Attorney for Health Care, a Declaration pursuant to the Natural Death Act, or a living will.

CIGNA HealthCare does not put conditions on providing care or otherwise discriminate against anyone based on whether or not that person has executed an *Advance Directive*. Please inform your Primary Care Physician if you have made an *Advance Directive*. At that time, you should also:

- provide a copy to your Primary Care Physician, and
- bring a copy with you when you check into a hospital or other health facility so that it can be readily available if needed.

It is CIGNA HealthCare policy that your wishes about treatment be followed whenever feasible. Should your doctor be unwilling to follow your directions, CIGNA HealthCare will assist in finding another physician or panel of physicians who will assume your care.

CIGNA HealthCare shall provide education to staff and the community on issues that concern *Advance Directives*.

Complaints concerning non-compliance with the *Advance Directive* requirements may be filed with the State survey and certification agency.

If you would like to either receive more information about Advance Directives or receive forms you can use to write a Living Will or Durable Power of Attorney, you may:

- Send $3.95 to Professional Media Resources, P. O. Box 460380, St. Louis, MO 63146-7380. Please specify the state for which you need the forms.
- Or call Choice in Dying, 2009 Varick St., 10th Floor, New York, NY 10014 at 1 (800) 989-WILL.
- Or call Eldercare Location at 1 (800) 677-1116 to receive the name of the local agency that may be able to help you.
- Or write or call the American Association of Retired Persons, Legal Counsel for the Elderly, Inc., Attn: Lisa Parrott-Heath, P.O. Box 96474, Washington, D.C. 20090-6474, (202) 434-2117.

Sources of Information and Forms

The following organizations provide health care directive forms and information:

- Aging and Adult Administration
  State of Arizona
  1789 W. Jefferson, Site code 950A
  Phoenix, Arizona 85007
  (602) 542-4446
- Area Agency on Aging
  Region One, Inc.
  1366 E. Thomas Road, Suite 108
  Phoenix, Arizona 85014
  (602) 264-4357
- Dorothy Garske Center*
  Your Health Care Choices Program
  4250 E. Camelback Road, Suite 185K
  Phoenix, Arizona 85018
  (602) 952-1464
- Pima Council on Aging
  5055 E. Broadway
  Suite C104
  Tucson, Arizona 85711
  (520) 790-7262
- Office of Arizona Attorney General
  Life Care Planning
  Information & Documents
  (602) 542-2124 phone
  (602) 542-4377 fax
  www.ag.state.az.us

*A Non-Profit Foundation, requesting fees or charitable donations for supplying directives.

GROUP SERVICE AGREEMENT

Section I. Definitions of Terms Used in This Group Service Agreement

The following definitions will help you in understanding the terms that are used in this Group Service Agreement. As you are reading this Group Service Agreement you can refer back to this section**.** We have identified defined terms throughout the Agreement by capitalizing the first letter of the term.

Agreement

This Agreement, the Face Sheet, the schedule of Copayments, any optional Riders, any other attachments, your Enrollment Application, and any subsequent written amendment or written modification to any part of the Agreement.

Anniversary Date of Agreement

The date written on the Face Sheet as the Agreement anniversary date.

Contract Year

The 12-month period beginning at 12:01 a.m. on the first day of the initial term or any renewal term and ending at 12:01 a.m. on the next anniversary of that date.

Copayment

The amount shown in the schedule of Copayments that you pay at the time that certain covered Services and Supplies are delivered. You are responsible for paying the Copayment at the time services are received. Covered Services and Supplies means the actual billed charges, except when the Participating Provider has contracted with the Healthplan to receive payment on a basis other than fee-for-service amount, the charge will be calculated based on a healthplan-determined percentage of actual billed charges.

Days

Calendar days; not 24 hour periods unless otherwise expressly stated.

Dependent

An individual in the Subscriber's family who is enrolled as a Member under this Agreement. You must meet the Dependent eligibility requirements in "Section II. Enrollment and Effective Date of Coverage" to be eligible to enroll as a Dependent.

Emergency Services

Emergency Services are defined in "Section IV. Covered Services and Supplies."

Enrollment Application

The enrollment process that must be completed by an eligible individual in order for coverage to become effective.

Face Sheet

The part of this Agreement that contains certain provisions affecting the relationship between the Healthplan and the Group. You can get a copy of the Face Sheet from the Group.

Group

The employer, labor union, trust, association, partnership, government entity, or other organization listed on the Face Sheet to this Agreement which enters into this Agreement and acts on behalf of Subscribers and Dependents who are enrolled as Members in the Healthplan.

Healthplan

The CIGNA HealthCare health maintenance organization (HMO) which is organized under applicable law and is listed on the Face Sheet to this Agreement. Also referred to as "we", "us" or "our".

Healthplan Medical Director

A Physician charged by the Healthplan to assist in managing the quality of the medical care provided by Participating Providers in the Healthplan; or his designee.

Medical Services

Professional services of Physicians or Other Participating Health Professionals (except as limited or excluded by this Agreement), including medical, psychiatric, surgical, diagnostic, therapeutic, and preventive services.

I. Definitions of Terms Used In this Group Service Agreement

Medically Necessary/Medical Necessity

Medically necessary covered Services and Supplies are those Services and Supplies that are determined by the Healthplan Medical Director to be:

- required to meet your essential health needs; and
- consistent with the diagnosis of the condition for which they are required; and
- consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; and
- required for purposes other than the convenience of the Provider or the comfort and convenience of the patient; and
- rendered in the least intensive setting that is appropriate for the delivery of health care; and

Member

An individual meeting the eligibility criteria as a Subscriber or a Dependent who is enrolled for Healthplan coverage and for whom all required Prepayment Fees have been received by the Healthplan. Also referred to as "you" or "your".

Membership Unit

The unit of Members made up of the Subscriber and his Dependent(s).

Open Enrollment Period

The period of time established by the Healthplan and the Group as the time when Subscribers and their Dependents may enroll for coverage. The Open Enrollment Period occurs at least once every Contract Year.

Other Participating Health Care Facility

Other Participating Health Care Facilities are any facilities other than a Participating Hospital or hospice facility that is operated by or has an agreement to render services to Members. Examples of Other Participating Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation hospitals and sub-acute facilities.

Other Participating Health Professional

An individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver Medical Services and who has an agreement with the Healthplan to provide services to Members. Other Participating Health Professionals include, but are not limited to physical therapists, home health aides and nurses.

Participating Hospital

An institution licensed as an acute care hospital under the applicable state law, which has an agreement to provide hospital services to Members.

Participating Physician

A Primary Care Physician (PCP) or other Physician who has an agreement to provide Medical Services to Members.

Participating Provider

Participating Providers are Participating Hospitals, Participating Physicians, Other Participating Health Professionals, and Other Participating Health Care Facilities.

Physician

An individual who is qualified to practice medicine under the applicable state law (or a partnership or professional association of such people) and who is a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.).

Prepayment Fee

The sum of money paid to the Healthplan by the Group in order for you to receive the Services and Supplies covered by this Agreement.

Primary Care Physician (PCP)

A Physician who practices general medicine, family medicine, internal medicine or pediatrics who, through an agreement with the Healthplan, provides basic health care services to you if you have chosen him as your Primary Care Physician (PCP). Your Primary Care Physician (PCP) also arranges specialized services for you.

I. Definitions of Terms Used In this Group Service Agreement

Primary Plan

The Plan that determines and provides or pays its benefits without taking into consideration the existence of any other Plan.

Prior Authorization

The approval a Participating Provider must receive from the Healthplan Medical Director, prior to services being rendered, in order for certain Services and Supplies to be covered under this Agreement.

Referral

The approval you must receive from your PCP in order for the services of a Participating Provider, other than the PCP, or participating OB/GYN, or chiropractic Physician to be covered.

Rider

An addendum to this Agreement between the Group and the Healthplan.

Schedule of Copayments

The section of this Agreement that identifies applicable Copayments and maximums.

Service Area

The geographic area, as described in the Provider Directory applicable to your plan, where the Healthplan is authorized to provide services.

Services and Supplies

Those Medically Necessary Services and Supplies described in "Section IV. Covered Services and Supplies."

Subscriber

An employee, or participant in the Group who is enrolled as a Member under this Agreement. You must meet the requirements contained in "Section II. Enrollment and Effective Date of Coverage" to be eligible to enroll as a Subscriber.

Total Copayment Maximum

The total amount of Copayments that an individual Member or Membership unit must pay within a Contract Year. When the individual Member or Membership unit has paid applicable Copayments up to the Total Copayment maximums, that Member or Membership unit will not be required to pay Copayments for those Services and Supplies for the remainder of the Contract Year. The Total Copayment maximums and the Copayments that apply toward these maximums are identified in the Schedule of Copayments.

Urgent Care

Urgent Care is defined in "Section IV. Covered Services and Supplies."

We/Us/Our

CIGNA HealthCare of Arizona, Inc.

You/Your

The Subscriber and/or any of his Dependents.

Section II. Enrollment and Effective Date of Coverage

Who Can Enroll as a Member

To be eligible for covered Services and Supplies you must be enrolled as a Member. To be eligible to enroll as a Member you must meet either the Subscriber or Dependent eligibility criteria listed below. You must also meet and continue to meet the Group-specific enrollment and eligibility rules on the Face Sheet.

A. To be eligible to enroll as a Subscriber, you must:

1. be an employee of the Group or a participant in the Group; and
2. reside or work in the Service Area; and
3. meet and continue to meet these criteria.

B. To be eligible to enroll as a Dependent, you must:

1. be the legal spouse of the Subscriber; or
2. be the natural child, step-child, or adopted child of the Subscriber; or the child for whom the Subscriber is the legal guardian, or the child legally placed with the Subscriber for adoption, or supported pursuant to a court order imposed on the Subscriber (including a qualified medical child support order), provided that the child:
   a. is unmarried and legally dependent upon the Subscriber for support;
      i. has not yet reached age nineteen (19); or
      ii. if the child is a full-time registered student in regular attendance at a secondary school, college or university or is a church missionary, has not yet reached age twenty-five (25). If the school is located outside the Service Area, he is still eligible to enroll and will be covered for Emergency Services and Urgent Care benefits while at school; or
      iii. the child is nineteen (19) or older and continuously incapable of self-sustaining support because of mental retardation or a physical handicap which existed prior to attaining nineteen (19) years of age [with respect to a student prior to attaining age twenty-five (25)]. You must submit proof of the child's condition and dependence to us within thirty-one (31) days after the date the child ceases to qualify as a Dependent under subsection (i) and (ii) above. We may, from time to time during the next two (2) years, require proof of the continuation of the child's condition and dependence. Thereafter, we may require such proof only once a year.

A Subscriber's grandchild is not eligible for coverage unless the grandchild meets the eligibility criteria for a Dependent.

NOTE: A child eligible to enroll as a Dependent under this Agreement who resides outside of the Service Area, is entitled to receive, while outside the Service Area, only out-of-area emergency benefits under the "Emergency Services" provision of the "Services and Benefits" section.

Enrollment and Effective Date of Coverage

A. Enrollment during an Open Enrollment Period

If you meet the Subscriber or Dependent eligibility criteria, you may enroll as a Member during the Open Enrollment Period by submitting a completed Enrollment Application, together with any applicable fees, to the Group.

If enrolled during the Open Enrollment Period, your effective date of coverage is the first day of the Contract Year.

B. Enrollment after an Open Enrollment Period

1. If, after the Open Enrollment Period, you become eligible for coverage as a Subscriber or a Dependent, you may enroll as a Member within sixty (60) days of the day on which you met the eligibility criteria. To enroll, you must submit an Enrollment Application, together with any additional

fees due, to the Group. If so enrolled, your effective date of coverage will be the day on which you meet the eligibility criteria.

If you do not enroll within the sixty (60) days, your next opportunity to enroll will be during the next Open Enrollment Period.

2. If you are a Subscriber who is enrolled as a Member, you may enroll a newborn child prior to the birth of the child or within thirty-one (31) days after the child's birth. A newborn child who is born while this Agreement is being paid for at OTHER than a single or two-party rate shall have coverage effective as of the date of birth. While not a pre-condition to such coverage, it is strongly recommended that a Subscriber submit to the Healthplan through the Group an enrollment application for the newborn child prior to the birth of the child or within thirty-one (31) days after birth to assist in the administration of the health care plan. Failure to inform the Healthplan of the birth of a child may result in a delay in the appropriate processing of claims for services.

   A newborn child who is born while this Agreement is being paid for at single or two-party rate shall have coverage effective as of the date of birth, if prior to the birth, the Subscriber submits to the Healthplan through the Group an enrollment application and pays the additional Prepayment Fees due. If these requirements are not met, the newborn child may be enrolled during the next designated Open Enrollment period.

3. If you are a Subscriber who is enrolled as a Member, you may enroll an adopted child or child for whom you have been granted legal guardianship within thirty-one (31) days of the date the child is legally placed with you for adoption or within 31 days of the date you are granted legal guardianship. A child who is legally adopted by or is placed with the Subscriber for adoption while this Agreement is being paid for at other than a single or two-party rate shall have coverage effective as of the date the child is placed with the Subscriber. While not a pre-condition to such coverage, it is strongly recommended that a Subscriber submit to the Healthplan through the Group an enrollment application for the adopted child within thirty-one (31) days after the date of placement to assist in the administration of the health care plan. Failure to inform the Healthplan of the adoption of a child may result in a delay in the appropriate processing if claims for services. If the child is placed with the Subscriber before the adoption process is completed, the Subscriber shall also submit to the Healthplan proof that the application and approval procedures for adoption pursuant to A.R.S. Section 8-105 or Section 8-108 have been completed.

   A child who is legally adopted by or is placed with the Subscriber for adoption by or is place with the Subscriber for adoption while this Agreement is being paid for at a single or two-party rate shall have coverage effective as of the date the child is placed with the Subscriber if, within thirty-one (31) days after the date of placement, the Subscriber submits to the Healthplan through the Group an enrollment application and the Group pays any additional Prepayment Fees due. If the child is placed with the Subscriber before the adoption process is completed, the Subscriber shall also submit to the Healthplan proof that the application and approval procedures for adoption pursuant to A.R.S. Section 8-105 or section 8-108 have been completed. If these requirements are not met but the adoption is later completed, the adopted child may be enrolled during the designated Open Enrollment Period. If the adoption process is not completed and coverage has been provided to a child under this Agreement, the Subscriber shall pay the Healthplan for all services and benefits provided to the child at prevailing rates for staff model services and at the contracted rates for other services.

C. Special Enrollment After Open Enrollment Period

There are special circumstances under which an individual who was eligible to enroll for coverage as a Subscriber, but did not do so, may

be eligible to enroll himself and any eligible Dependents outside of the Open Enrollment Period.

After the Open Enrollment Period, you may submit an Enrollment Application and any applicable fees, to the Group, for yourself and any eligible Dependent(s) within thirty-one (31) days of the date of the following events:

1. Marriage;
2. Birth of a dependent newborn child; or
3. Adoption of a dependent child or legal placement of a child for adoption.

If so enrolled, the effective date of coverage will be the day of the event creating eligibility.

If you do not enroll within the thirty-one (31) days of one of these events, the next opportunity for you and any eligible Dependents to enroll will be during the next Open Enrollment Period.

D. Enrollment Due to Loss of Prior Creditable Coverage

If you and/or your Dependent(s) did not enroll as a Member during the Open Enrollment Period because you and/or your Dependent(s) had other creditable health care coverage, you may be eligible to enroll for coverage under this plan if you later lose that coverage. You must submit to the Group an Enrollment Application, and any applicable fees due within thirty-one (31) days of the day that you or your Dependent(s):

1. are no longer eligible for the other coverage for any reason (including separation, divorce or death of the Subscriber);
2. lost the other coverage because an employer or plan sponsor failed to pay required premium or fees; or
3. completed continuation of other coverage as provided under federal or state law.

If so enrolled, the effective date of coverage will be the first day of the month following the day on which the Healthplan received the Enrollment Application.

If these conditions are not met, or if you do not submit an Enrollment Application within thirty-one (31) days of one of these events, the next opportunity for you and any eligible Dependent(s) to enroll will be during the next Open Enrollment Period.

E. Full and Accurate Completion of Enrollment Application

Each Subscriber must fully and accurately complete the Enrollment Application. False, incomplete or misrepresented information provided in any Enrollment Application may, in the Healthplan's sole discretion, cause the coverage of the Subscriber and/or his Dependents to be null and void from its inception.

F. Hospitalization on the Effective Date of Coverage

If you are confined in a hospital on the effective date of your coverage, you must notify us of such a hospitalization within two (2) days, or as soon as reasonably possible thereafter. When you become a Member of the Healthplan, you agree to permit the Healthplan to assume direct coordination of your health care. We reserve the right to transfer you to the care of a Participating Provider and/or Participating Hospital if the Healthplan Medical Director, in consultation with your attending Physician, determines that it is medically safe to do so.

If you are hospitalized on the effective date of coverage and you fail to notify us of this hospitalization, refuse to permit us to coordinate your care, or refuse to be transferred to the care of a Participating Provider or Participating Hospital, we will not be obligated to pay for any medical or hospital expenses that are related to your hospitalization following the first two (2) days after your coverage begins.

Section III. Agreement Provisions

A. Healthplan's Representations and Disclosures

1. The Healthplan is a for-profit health maintenance organization (HMO) which arranges for the provision of covered Services and Supplies through a network of Participating Providers. The list of Participating Providers is provided to all Members at enrollment without charge. If you would like another list of Participating Providers, please contact Member Services at the toll-free number found on your CIGNA HealthCare ID card or visit the CIGNA HealthCare web site at www.cigna.com.
2. With the exception of any employed Physicians who work in a facility operated by the Healthplan (so-called "staff model" providers), the Participating Providers are independent contractors. They are not the agents or employees of the Healthplan and they are not under the control of the Healthplan or any CIGNA company. All Participating Providers are required to exercise their independent medical judgment when providing care.
3. The Healthplan maintains all medical information concerning a Member as confidential in accordance with applicable laws and professional codes of ethics. A copy of the Healthplan's confidentiality policy is available upon request.
4. We do not restrict communication between Participating Providers and Members regarding treatment options.
5. Under federal law (the Patient Self-Determination Act), you may execute advance directives, such as living wills or a durable power of attorney for health care, which permit you to state your wishes regarding your health care should you become incapacitated.
6. Upon your admission to a participating inpatient facility, a Participating Physician other than your PCP may be asked to direct and oversee your care for as long as you are in the inpatient facility. This Participating Physician is often referred to as an "inpatient manager" or "hospitalist."
7. The terms of this Agreement may be changed in the future either as a result of an amendment agreed upon by the Healthplan and the Group or to comply with changes in law. The Group or the Healthplan may terminate this Agreement as specified in this Agreement. In addition, the Group reserves the right to discontinue offering any plan of coverage.
8. **Choosing a Primary Care Physician**

   When you enroll as a Member, you must choose a Primary Care Physician (PCP). Each covered Member of your family must also choose a PCP. If you do not select a PCP, we will assign one for you. If your PCP leaves the CIGNA HealthCare network, you will be able to choose a new PCP. You may voluntarily change your PCP for other reasons but not more than once in any calendar month. We reserve the right to determine the number of times during a Contract Year that you will be allowed to change your PCP. If you select a new PCP before the fifteenth day of the month, the designation will be effective on the first day of the month following your selection. If you select a new PCP on or after the fifteenth day of the month, the designation will be effective on the first day of the month following the next full month. For example, if you notify us on June 10, the change will be effective on July 1. If you notify us on June 15, the change will be effective on August 1.

   Your choice of a PCP may affect the specialists and facilities from which you may receive services. Your choice of a specialist may be limited to specialists in your PCP's medical group or network. Therefore, you may not have access to every specialist or Participating Provider in your Service Area. Before you select a PCP, you should check to see if that PCP is associated with the specialist or facility you prefer to use. If the Referral is not possible, you should ask the specialist or facility about which PCPs can make Referrals to them,

and then verify the information with the PCP before making your selection.

9. Referrals to Specialists

You must obtain a Referral from your PCP before visiting any provider other than your PCP in order for the visit to be covered. The Referral authorizes the specific number of visits that you may make to a provider within a specified period of time. If you receive treatment from a provider other than your PCP without a Referral from your PCP, the treatment is not covered.

Exceptions to the Referral process:

If you are a female Member, you may visit a qualified Participating Provider for covered obstetrical and gynecological services, as defined in "Section IV. Covered Services and Supplies," without a Referral from your PCP.

You do not need a Referral from your PCP for Emergency Services as defined in the "Section IV. Covered Services and Supplies." In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a Referral from your PCP for Emergency Services, but you do need to call your PCP as soon as possible for further assistance and advice on follow-up care.

In an emergency, you should seek immediate medical attention and then as soon as possible thereafter you need to call your PCP for further assistance and advice on follow-up care.

In an Urgent Care situation a Referral is not required but you should, whenever possible, contact your PCP for direction prior to receiving services.

Standing Referral to Specialist

You may apply for a standing referral to a provider other than your PCP when all of the following conditions apply:

1. You are a covered member of the Healthplan;
2. You have a disease or condition that is life threatening, degenerative, chronic or disabling;
3. Your PCP in conjunction with network specialist determines that your care requires another provider's expertise;
4. Your PCP determines that your disease or condition will require ongoing medical care for an extended period of time;
5. The standing referral is made by your PCP to a network specialist who will be responsible for providing and coordinating your specialty care; and
6. The network specialist is authorized by the Healthplan to provide the services under the standing referral.

We may limit the number of visits and time period for which you may receive a standing referral. If you receive a standing referral or any other referral from your PCP, that referral remains in effect even if the PCP leaves the Healthplan's network. If the treating specialist leaves the Healthplan's network or you cease to be a covered member, the standing referral expires.

10. Choosing a Primary Care Physician

When you enroll as a Member, you may choose a Primary Care Physician (PCP) to be your personal doctor and serve as your health care manager. If you select a PCP his name will appear on your ID card. You may directly contact any PCP or other Participating Physician listed in the provider directory for your Service Area. You do not need a referral.

If your PCP leaves the CIGNA HealthCare network, you will be able to choose a new PCP. You may voluntarily change your PCP for other reasons but not more than once in any calendar month. You may also select a PCP at any time, if you did not select a PCP when you enrolled. We reserve the right to determine the number of times during a Contract Year that you will be

allowed to change your PCP. If you select a new PCP before the fifteenth day of the month, the designation will be effective on the first day of the month following your selection. If you select a new PCP on or after the fifteenth day of the month, the designation will be effective on the first day of the month following the next full month. For example, if you notify us on June 10, the change will be effective on July 1. If you notify us on June 15, the change will be effective on August 1.

11. Transition Care

There may be instances in which your PCP becomes unaffiliated with the Healthplan's network of Participating Providers. In such cases, you will be notified and provided assistance in selecting a new PCP.

However, in special circumstances, you may be able to continue seeing your doctor, even though he or she is no longer affiliated with the Healthplan. If you are a new Member, upon written request to the Healthplan, you may continue an active course of treatment with your current health care provider during a transitional period after the effective date of enrollment if both of the following apply:

1. You have a life threatening disease or condition, in which case the transitional period will not be more than thirty (30) days after the effective date of enrollment;
2. Entered the third trimester of pregnancy on the effective date of enrollment, in which case the transitional period includes the delivery and any care up to six weeks after the delivery that is related to the delivery.

If you have been receiving care and a continued course of covered treatment is Medically Necessary, you may be eligible to receive "transitional care" from the non-participating provider for up to thirty (30) days. You may also be eligible to receive transitional care if you are in your second trimester of pregnancy. In this case, transitional care may continue through your delivery and post-partum care. Such transitional care must be approved in advance by the Healthplan, and your doctor must agree to accept our reimbursement rate and to abide by the Healthplan's policies and procedures and quality assurance requirements. There may be additional circumstances where continued care by a provider no longer participating in the Healthplan's network will not be available, such as when the provider loses his license to practice or retires.

If you are a new Member whose health care provider is not a member of the Healthplan's network and you (i) are receiving an on-going course of treatment for a life-threatening disease or condition, or a degenerative or disabling disease or condition, or (ii) have entered your second trimester or pregnancy as of the effective date of your enrollment, you may be eligible to receive continuity of care from that non-participating provider for a transitional period of up to sixty (60) days, or the post partum period directly related to the delivery of your child. Such continuity of care must be approved in advance by the Healthplan, and your doctor must agree to accept our reimbursement rate and to abide by the Healthplan policies and procedures and quality assurance requirements. There may be additional circumstances where continued care by a provider no longer participating in the Healthplan's network will not be available, such as when the provider loses his/her license to practice or retires.

12. Provider Compensation

We compensate our Participating Providers in ways that are intended to emphasize preventive care, promote quality of care, and assure the most appropriate use of Medical Services. You can discuss with your provider how he is compensated by us. The methods we use to compensate Participating Providers are:

Discounted fee for service – payment for service is based on an agreed upon discounted amount for the services provided.

Capitation – Physicians, provider groups and Physician/hospital organizations are paid a fixed amount at regular intervals for each Member assigned to the Physician, provider group or Physician/hospital organization, whether or not services are provided. This payment covers Physician and/or, where applicable, hospital or other services covered under the benefit plan. Medical groups and Physician/hospital organizations may in turn compensate providers using a variety of methods.

Capitation offers health care providers a predictable income, encourages Physicians to keep people well through preventive care, eliminates the financial incentive to provide services that will not benefit the patient, and reduces paperwork.

Providers paid on a "capitated" basis may participate with us in a risk sharing arrangement. They agree upon a target amount for the cost of certain health care services, and they share all or some of the amount by which actual costs are over target. Provider services are monitored for appropriate utilization, accessibility, quality and Member satisfaction.

We may also work with third parties who administer payments to Participating Providers. Under these arrangements, we pay the third party a fixed monthly amount for these services. Providers are compensated by the third party for services provided to Healthplan participants from the fixed amount. The compensation varies based on overall utilization.

Salary – Physicians and other providers who are employed to work in our medical facilities are paid a salary. The compensation is based on a dollar amount, decided in advance each year, that is guaranteed regardless of the services provided. Physicians are eligible for any annual bonus based on quality of care, quality of service and appropriate use of Medical Services.

Bonuses and Incentives – Eligible Physicians may receive additional payments based on their performance. To determine who qualifies, we evaluate Physician performance using criteria that may include quality of care, quality of service, accountability and appropriate use of Medical Services.

Per Diem – A specific amount is paid to a hospital per day for all health care received. The payment may vary by type of service and length of stay.

Case Rate – A specific amount is paid for all the care received in the hospital for each standard service category as specified in our contract with the provider (e.g., for a normal maternity delivery).

B. Member's Rights, Roles and Representations

You have the right to:

1. Medical treatment that is available when you need it and is handled in a way that respects your privacy and dignity.
2. Get the information you need about your health care plan, including information about services that are covered, services that are not covered, and any costs that you will be responsible for paying.
3. Have access to a current list of providers in our network and have access to information about a particular provider's education, training and practice.
4. Select a Primary Care Physician (PCP) for yourself and each covered Member of your family, and to change your PCP for any reason.
5. Have your medical information kept confidential by our employees and your health care provider. Confidentiality laws and professional rules of behavior allow us to release medical information only when it's required for your care, required by law, necessary for the administration of your plan or to support our programs or operations that evaluate quality and service. We may also summarize information in reports that do not identify you or any other participants specifically.

6. Have your health care provider give you information about your medical condition and your treatment options, regardless of benefit coverage or cost. You have the right to receive this information in terms you understand.
7. Learn about any care you receive. You should be asked for your consent to all care unless there is an emergency and your life and health are in serious danger.
8. Refuse medical care. If you refuse medical care, your health care provider should tell you what might happen. We urge you to discuss your concerns about care with your PCP or another Participating Physician. Your doctor will give you advice, but you will always have the final decision.
9. Be heard. Our complaint-handling process is designed to hear and act on your complaint or concern about us and/or the quality of care you receive, provide a courteous, prompt response, and to guide you through our appeals process if you do not agree with our decision.
10. Make recommendations regarding our policies on Member rights and responsibilities. If you have recommendations, please contact Member Services at the toll-free number on your CIGNA HealthCare ID card.

Your role is to:

1. Review and understand the information you receive about your health care plan. Please call CIGNA HealthCare Member Services when you have questions or concerns.
2. Understand how to obtain covered Services and Supplies that are provided under your plan.
3. Show your CIGNA HealthCare ID card before you receive care.
4. Schedule a new patient appointment with any new CIGNA HealthCare PCP; build a comfortable relationship with your doctor; ask questions about things you don't understand; and follow your doctor's advice. You should also understand that your condition may not improve and may even get worse if you don't follow your doctor's advice.
5. Understand your health condition and work with your doctor to develop treatment goals that you both agree upon, to the extent that this is possible.
6. Provide honest, complete information to the providers caring for you.
7. Know what medicine you take, why, and how to take it.
8. Pay all Copayments for which you are responsible at the time the service is received.
9. Keep scheduled appointments and notify the doctor's office ahead of time if you are going to be late or miss an appointment.
10. Pay all charges for missed appointments and for services that are not covered by your plan.
11. Voice your opinions, concerns or complaints to CIGNA HealthCare Member Services and/or your provider.
12. Notify your employer as soon as possible about any changes in family size, address, phone number or membership status.

You represent that:

1. The information provided to us and the Group in the Enrollment Application is complete and accurate.
2. By enrolling in the Healthplan, you accept and agree to all terms and conditions of this Agreement.
3. By presenting your CIGNA HealthCare ID card and receiving treatment and services from our Participating Providers, you authorize the following to the extent allowed by law:
   a. any provider to provide us with information and copies of any records related to your condition and treatment;
   b. any person or entity having confidential information to provide any such confidential information upon request to us, any Participating Provider, and any

other provider or entity performing a service, for the purpose of administration of the plan, the performance of any Healthplan program or operations, or assessing or facilitating quality and accessibility of health care Services and Supplies;

c. us to disclose confidential information to any persons, company or entity to the extent we determine that such disclosure is necessary or appropriate for the administration of the plan, the performance of the Healthplan programs or operations, assessing or facilitating quality and accessibility of healthcare Services and Supplies, or reporting to third parties involved in plan administration; and

d. that payment be made under Part B of Medicare to us for medical and other services furnished to you for which we pay or have paid, if applicable.

This authorization will remain in effect until you send us a written notice revoking it or for such shorter period as required by law. Until revoked, we and other parties may rely upon this authorization.

With respect to Members, confidential information includes any medical, dental, mental health, substance abuse, communicable disease, AIDS and HIV related information and disability or employment related information.

4. You will not seek treatment as a CIGNA HealthCare Member once your eligibility for coverage under this Agreement has ceased.

C. When You Have a Complaint or an Appeal

(For the purposes of this section, any reference to "you", "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.)

We want you to be completely satisfied with the care you receive. That's why we've established a process for addressing your concerns and solving your problems. The following describes the process by which Members may obtain information and submit concerns regarding service, benefits, and coverage. For more information, see the Benefit Inquiry and Appeals Information Packet ("Appeal Packet"). Upon membership renewal or at any time thereafter, you may request an additional Appeal Packet by contacting Member Services at the toll-free number that appears on your CIGNA HealthCare ID card or Benefit Identification card.

Start with Member Services

We're here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call us at our toll-free number and explain your concern to one of our Customer Services representatives. You can also express that concern in writing. Please call or write to us at the following:

Appeals Processor Appeals Unit
CIGNA HealthCare National Appeals Unit
400 N. Brand Blvd.
Glendale, CA 91203

Customer Services Toll-Free Number that appears on your CIGNA HealthCare ID card or Benefit Identification card

We'll do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we'll get back to you as soon as possible, but in any case within thirty (30) days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

HEALTHPLAN has a three step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing at the address shown above within two (2) years of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by calling the toll-free number on your CIGNA HealthCare ID card or Benefit Identification card.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

Within five (5) business days after receiving your request for review, the Healthplan will mail you and your Primary Care Physician ("PCP") or treating Provider a notice indicating that your request was received, and a copy of the Appeal Packet (sent to PCP or treating Provider upon request). For level one appeals, we will respond in writing with a decision within fifteen (15) calendar days after we receive an appeal for a pre-service or concurrent coverage determination, and within thirty (30) calendar days after we receive an appeal for a post-service coverage determination. If more time or information is needed to make the pre-service or concurrent determination, we will notify you in writing to request an extension of up to fifteen calendar days and to specify any additional information needed to complete the review. You may request that the appeal process be expedited if, your PCP or treating Provider certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services; or your appeal involves non-authorization of an admission or continuing inpatient hospital stay. When an appeal is expedited, we will respond orally and in writing with a decision within the lesser of one (1) business day or seventy-two (72) hours.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, you must submit a request for the appeal in writing to the following address:

Appeals Processor Appeals Unit
CIGNA HealthCare National Appeals Unit
400 N. Brand Blvd.
Glendale, CA 91203

Please send your review request relating to denial of a requested service that has not already been provided within 365 days of the last denial. Your review requests relating to payment of a service already provided should be sent within two (2) years of the last denial. To help us make a decision on your appeal, you or your provider should also send us any more information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim.

Most requests for a second review will be conducted by the Appeals Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving Medical Necessity or clinical appropriateness the committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by the Healthplan Medical Director. You may present your situation to the committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request within 5 business days after receiving your request and schedule a committee review. For pre-service and concurrent care coverage determinations the committee review will be completed within fifteen (15) calendar days and for post-service claims, the committee review and written notification of the Appeals Committee's decision will be completed within thirty (30) calendar days. If more time or information is needed to make the pre-service or concurrent determination, we will notify you in writing to request an extension of up to fifteen (15) calendar days and to specify any additional information needed by the Appeals Committee to complete the review. You may request that the appeal process be expedited if, your PCP or treating Provider certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the

requested services; or your appeal involves non-authorization of an admission or continuing inpatient hospital stay. When an appeal is expedited, we will respond orally with a decision within seventy-two (72) hours, followed up in writing.

After completing the Level One appeal process the Healthplan has the option to send your appeal directly to External Independent Review without making a decision at the Level Two appeal process.

External Independent Review

1. Eligibility

Under Arizona law, a Member may seek an Expedited or Standard External Independent Review only after seeking any available Expedited Review, Level 1 Appeal, and Level 2 Appeal. Your request for an Expedited or Standard External Independent Review should be submitted in writing.

2. Deadlines Applicable to the Standard External Independent Review Process

After receiving written notice from the Healthplan that your Level 2 Appeal has been denied, you have thirty (30) calendar days to submit a written request to the Healthplan for External Independent Review, including any additional material justification or documentation that you have not already sent to us to support your request for the service or payment of a claim.

a. Medical Necessity Issues

These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review. If your appeal for External Independent Review involves an issue of medical necessity:

(1) Within five (5) business days of receipt of your request for External Independent Review, the Healthplan will:

- mail a written notice to you, your PCP or treating provider, and the Director of the Arizona Department of Insurance ("Director of Insurance") of your request for External Independent Review, and
- Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

(2) Within 5 days of receiving our information, the Insurance Director must send all submitted information to an external independent review organization (the "IRO").

(3) Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

(4) Within 5 business days of receiving the IRO's decision, The Insurance Director must mail a notice of the decision to us, you, and your treating provider. If the IRO decides that the Healthplan should provide the service or pay the claim, the Healthplan must then authorize the service or pay the claim. If the IRO agrees with the Healthplan's decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.

b. Coverage Issues

These are cases where we have denied coverage because we believe

the requested service is not covered under your evidence of coverage. For contract coverage cases, the Arizona Insurance Department is the independent reviewer. If your appeal for External Independent Review involves an issue of service or benefits coverage or a denied claim:

(1) Within five (5) business days of receipt of your request for External Independent Review, the Healthplan will:

- mail a written notice to you, your PCP or treating provider, and the Director of Insurance of your request for External Independent Review, and
- send the Director of Insurance: your request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

(2) Within fifteen (15) business days of the Director's receipt of your request for External Independent Review from the Healthplan, the Director of Insurance will:

- determine whether the service or claim is covered, and
- mail the decision to the Healthplan. If the Director decides that we should provide the service or pay the claim, we must do so.

(3) If the Director of Insurance is unable to determine an issue of coverage, the Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have 5 business days after receiving the IRO's decision to send the decision to us, you, and your treating provider.

(4) The Healthplan will provide any covered service or pay any covered claim determined to be medically necessary by the independent reviewer(s) and provide any service or pay any claim determined to be covered by the Director of Insurance regardless of whether the Healthplan elects to seek judicial review of the decision made through the External Independent Review Process.

(5) If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If the Healthplan disagrees with the Insurance Director's final decision, the Healthplan may also request a hearing before the OAH. A hearing must be requested within 30 calendar days of receiving the Insurance Director's decision. OAH will schedule and complete a hearing for appeals from standard external independent review coverage decisions.

3. Deadlines Applicable to the Expedited External Independent Review Process

After receiving written notice from the Healthplan that your Expedited Level 2 Appeal has been denied, you have only 5 business days to submit a written request to the Healthplan for an Expedited External Independent Review. Your request should include any additional material justification or documentation that you have not already sent to us to support your request for the service or payment of a claim.

a. Medical Necessity Issues

If your appeal for Expedited External Independent Review involves an issue of medical necessity:

(1) Within 1 business day of receipt of your request for an Expedited External Independent Review, the Healthplan will:

- mail a written acknowledgment to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and
- forward to the Director your request for an Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of the Healthplan's decision, the criteria used and the clinical reasons for the decision, relevant portions of the Healthplan's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.

(2) Within 2 business days after the Director receives the information outlined above, the Director will choose an independent review organization (IRO) and forward to the organization all of the information received by the Director.

(3) Within 5 business days of receiving a case for Expedited External Independent Review from the Director, the IRO will evaluate and analyze the case and based on all the information received, render a decision and send the decision to the Director. Within 1 business day after receiving a notice of the decision from the IRO, the Director will mail a notice of the decision to you, your PCP or treating provider, and the Healthplan.

b. Coverage Issues

If your appeal for Expedited External Independent Review involves a contract coverage issue:

(1) Within 1 business day of receipt of your request for an Expedited External Independent Review, the Healthplan will:

- mail a written acknowledgment to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and
- forward to the Director your request for an Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of the Healthplan's decision, the criteria used and the clinical reasons for the decision, relevant portions of the Healthplan's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.

(2) Within 2 business days after receipt of all the information outlined above, the Director will determine if the service or claim is covered and mail a notice of the determination to you, your PCP or treating provider, and the Healthplan.

(3) If the Director of Insurance is unable to determine an issue of coverage, the Director will forward your case to an IRO. The IRO will have 5 business days to make a decision and send it to the Director. The Director will have 1 business day after receiving the IRO's decision to send the decision to the Healthplan, you and your treating provider.

(4) The Healthplan will provide any covered service or pay any covered claim determined to be medically necessary by the independent

reviewer(s) and provide any service or pay any claim determined to be covered by the Director regardless of whether the Healthplan elects to seek judicial review of the decision made through the External Independent Review Process.

(5) If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If the Healthplan disagrees with the Director's final decision, the Healthplan may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision.

Under Arizona law, if you intend to file suit regarding a denial of benefit claim or services you believe are medically necessary, you are required to provide written notice to the Healthplan at least thirty (30) days before filing the suit stating your intention to file suit and the basis for your suit. You must include in your notice the following:

Member Name
Member Identification Number
Member Date of Birth
Basis of Suit (reasons, facts, date(s) of treatment or request)

Notice will be considered provided by you on the date received by the Healthplan. The notice of intent to file suit must be sent to the Healthplan via Certified Mail Return Receipt Request to the following address:

Attention: National Appeals Unit Director
Notice of Intent to File Suit
CIGNA HealthCare of Arizona
400 N. Brand Blvd.
Glendale, CA 91203

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written documents required to be mailed during the process is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

Complaints to the Arizona Department of Insurance

The Director of the Arizona Department of Insurance is required by law to require any Member who files a complaint with the Arizona Department of Insurance relating to an adverse decision to first pursue the review process established by the Arizona Legislature and the Healthplan as described above.

Appeal to the State of Arizona

If you need help in filing an appeal, or you have questions about the appeals process, you may call the Department's Consumer Assistance Office at 602.912.8444 or 1.800.325.2548

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and will include (items 3, 4, and 5 are only included for adverse determinations): (1) the specific reason or reasons for the determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to

contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which was (a) relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against HEALTHPLAN until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

Section IV. Covered Services And Supplies

The covered Services and Supplies available to Members under this plan are described below. Any applicable Copayments or limits are identified in the Schedule of Copayments.

Unless otherwise authorized in writing by the Healthplan Medical Director, covered Services and Supplies are available to Members only if:

- **They are medically necessary and not specifically excluded in this Section or in Section V.**
- **Provided by your Primary Care Physician (PCP) or if your PCP has given you a Referral, by another Participating Provider. However, "Emergency Services" do not require a Referral from your PCP and do not have to be provided by Participating Providers. Also, you do not need a Referral from your PCP for "Urgent Care", and any services covered under this Agreement which are provided by a Participating Obstetrician/Gynecologist.**
- **Prior Authorization is obtained from the Healthplan Medical Director by the Participating Provider, for those services that require Prior Authorization. Services that require Prior Authorization include, but are not limited to, inpatient hospital services, inpatient services at any Other Participating Health Care Facility, outpatient facility services, magnetic resonance imaging, non-emergency ambulance, and organ transplant services.**

Physician Services

All diagnostic and treatment services provided by Participating Physicians and Other Participating Health Professionals, including office visits, periodic health assessments, well-child care and routine immunizations provided in accordance with accepted medical practices, hospital care, consultation, and surgical procedures.

Inpatient Hospital Services

Inpatient hospital services for evaluation or treatment of conditions that cannot be adequately treated on an ambulatory basis or in an Other Participating Health Care Facility. Inpatient hospital services include semi-private room and board; care and services in an intensive care unit; drugs, medications, biologicals, fluids, blood and blood products, and chemotherapy; special diets; dressings and casts; general nursing care; use of operating room and related facilities; laboratory and radiology services and other diagnostic and therapeutic services; anesthesia and associated services; inhalation therapy; radiation therapy; and other services which are customarily provided in acute care hospitals.

Outpatient Facility Services

Services provided on an outpatient basis, including: diagnostic and/or treatment services; administered drugs, medications, fluids, biologicals, blood and blood products; inhalation therapy; and procedures which can be appropriately provided on an outpatient basis, including certain surgical procedures, anesthesia, and recovery room services.

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Emergency Services and Urgent Care

Emergency Services Both In and Out of the Service Area. In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a Referral from your PCP for Emergency Services, but you do need to call your PCP as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP will coordinate it and handle the necessary authorizations for care or hospitalization. Participating Providers are on call twenty-four (24) hours a day, seven (7) days a week, to assist you when you need Emergency Services.

If you receive Emergency Services outside the Service Area, you must notify us as soon as reasonably possible. We may arrange to have you transferred to a Participating Provider for continuing or follow-up care if it is determined to be medically safe to do so.

Emergency Services are defined as the medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service, which are required for relief of acute pain, for the initial treatment of acute infection or to treat a sudden unexpected onset of a bodily injury or a

serious illness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital on the UB92 claim form or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency. You are covered for at least a screening examination to determine whether an emergency exists. Care up and through stabilization for emergency situations is covered without prior authorization.

Urgent Care Inside the Service Area. For Urgent Care inside the Service Area, you must take all reasonable steps to contact your PCP for direction and you must receive care from a Participating Provider, unless otherwise authorized by your PCP or the Healthplan.

Urgent Care Outside the Service Area. In the event you need Urgent Care while outside the Service Area, you should, whenever possible, contact the CIGNA HealthCare 24 Hour Health Information Line SM or your PCP for direction and authorization prior to receiving services.

Urgent Care is defined as medical, surgical, hospital and related health care services and testing which are not Emergency Services, but which are determined by the Healthplan Medical Director in accordance with generally accepted medical standards to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or are scheduled to receive services. Such care includes but is not limited to: dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that you should not travel due to any medical condition.

Continuing or Follow-up Treatment. Continuing or follow-up treatment, whether in or out of the Service Area, is not covered unless it is provided or arranged for by your PCP or upon Prior Authorization of the Healthplan Medical Director.

Notification, Proof of a Claim, and Payment. Inpatient hospitalization for any Emergency Services or Urgent Care requires notification to and authorization by the Healthplan Medical Director. Notification of inpatient hospitalization is required as soon as reasonably possible, but no later than within forty-eight (48) hours of admission. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided that notification is given to us as soon as reasonably possible. If you receive Emergency Services or Urgent Care from non-Participating Providers, you must submit a claim to us no later than sixty (60) days after the first service is provided. The claim shall contain an itemized statement of treatment, expenses, and diagnosis. This requirement shall not cause denial of an otherwise valid claim if you could not reasonably comply, provided you submit the claim and the itemized statement to us as soon as reasonably possible. Coverage for Emergency Services and Urgent Care received through non-Participating Providers shall be limited to covered services to which you would have been entitled under this Agreement, and shall be reimbursed at the prevailing rate for self-pay patients in the area where the services were provided.

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Ambulance Service

Ambulance services to the nearest appropriate provider or facility. Prior authorization for non-emergency ambulance services may be obtained from a Participating Provider that is treating the Member.

Breast Reconstruction and Breast Prostheses

Following a mastectomy, the following Services and Supplies are covered:

- surgical services for reconstruction of the breast on which the mastectomy was performed;

- surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance;
- post-operative breast prostheses; and
- mastectomy bras and external prosthetics that meet external prosthetic placement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Cancer Clinical Trials

Coverage shall be provided for medically necessary covered patient costs that are directly associated with a cancer clinical trial that is offered in the State of Arizona and in which the Member participates voluntarily. A cancer clinical trial is a course of treatment in which all of the following apply:

1. The treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution in the State of Arizona, that is for the treatment, palliation or prevention of cancer in humans and in which the scientific study includes all of the following: (a) specific goals; (b) a rationale and background for the study; (c) criteria for patient selection; (d) specific directions for administering the therapy and monitoring patients; (e) definition of quantitative measures for determining treatment response; and (f) methods for documenting and treating adverse reactions.
2. The treatment is being provided as part of a study being conducted in a phase I, phase II, phase III or phase IV cancer clinical trial.
3. The treatment is being provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following: (a) One of the National Institutes of Health; (b) A National Institutes of Health Cooperative Group or Center; (c) The United States Food and Drug Administration in the form of an investigational new drug application; (d) The United States Department of Defense; (e) The United States Department of Veteran Affairs; (f) a qualified research entity that meets the criteria established by the National Institutes of Health for grant eligibility; or (g) a panel of qualified recognized experts in clinical research within academic health institutions in the State of Arizona.
4. The proposed treatment or study has been reviewed and approved by an institutional review board of an institution in the State of Arizona.
5. The personnel providing the treatment or conducting the study (a) are providing the treatment or conducting the study within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training and volume of patients treated to maintain expertise; (b) agree to accept reimbursement as payment in full from the Healthplan at the rates that are established by the Healthplan and that are not more than the level of reimbursement applicable to other similar services provided by the health care providers with the Healthplan's network.
6. There is no clearly superior, non-investigational treatment alternative.
7. The available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as efficacious as any non-investigational alternative.

For the purposes of this specific covered Service and Benefit the following have the following meaning:

1. "Cooperative Group" – means a formal network of facilities that collaborates on research projects and that has an established national institutes of health approved peer review program operating within the group, including the National Cancer Institute Clinical Cooperative Group and The National Cancer Institute Community Clinical Oncology Program.
2. "Institutional Review Board" – means any board, committee or other group that is both: (a) formally designated by an institution to approve the initiation of and to conduct periodic review of biomedical research involving human subjects and in which the primary purpose of such review is to assure the protection of the rights and welfare of the human subjects and not to review a clinical trial for scientific merit;

and (b) approved by the National Institutes of Health Office for Protection From Research Risks.

3. "Multiple Project Assurance Contract" – means a contract between an institution and the United States Department of Health and Human Services that defines the relationship of the institution to the United States Department of Health and Human Services and that sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

4. "Patient Cost" – means any fee or expense that is covered under the Evidence of Coverage and that is for a service or treatment that would be required if the patient were receiving usual and customary care. Patient Cost does not include the cost: (a) of any drug or device provided in a phase I cancer clinical trial; (b) of any investigational drug or device; (c) of non-health services that might be required for a person to receive treatment or intervention; (d) of managing the research of the clinical trial; (e) that would not be covered under the Member's contract; and (f) of treatment or services provided outside the State of Arizona.

Diabetic Service and Supplies

Coverage will be provided for the following Medically Necessary supplies, devices, and appliances prescribed by a health care provider for the treatment of diabetes: Test strips for glucose monitors and visual reading and urine testing strips; insulin preparations; glucagon; insulin cartridges and insulin cartridges for the legally blind; syringes and lancets (including automatic lancing devices); oral agents for controlling blood sugar that are included on the Formulary; blood glucose monitors and blood glucose monitors for the legally blind; and injection aids; to the extent coverage is required under Medicare, podiatric appliances for prevention of complications associated with diabetes; and any other device, medication, equipment or supply for which coverage is required under Medicare.

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Durable Medical Equipment

Purchase or rental of durable medical equipment that is ordered or prescribed by a Participating Physician and provided by a vendor approved by the Healthplan for use outside a Participating Hospital or Other Participating Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a member's misuse are the member's responsibility.

Durable medical equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of illness or injury; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, wheel chairs, respirators, and dialysis machines. Durable Medical Equipment items that are not covered, include but are not limited to those that are listed below.

- **Bed related items:** bed trays , over the bed tables, bed wedge, custom bedroom equipment, non-power mattress, pillows, posturpedic mattresses, low air loss mattresses (powered), alternating pressure mattresses.
- **Bath related items:** Bath lifts, non-portable whirlpool, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held shower, paraffin baths, bath mats, spas.
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geri chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized - manual hydraulic lifts are covered if patient is two person transfer), vitrectomy chairs, auto tilt chairs and fixtures to real property (ceiling lifts, wheelchair ramps, automobile lifts-customizations).
- **Air quality items:** room humidifiers, vaporizers, air purifiers, electrostatic machines.
- **Blood/injection related items:** blood pressure cuffs, centrifuges, nova pens, needle-less injectors.
- **Pumps:** back packs for portable pumps.
- **Other equipment:** heat lamp, heating pad, cryounits, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, Enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators,

saunas, exercise equipment, diathermy machines.

Erectile Dysfunction

Medical diagnostic services to determine the cause of erectile dysfunction. Penile implants are covered when you have an established medical condition that clearly causes erectile dysfunction, such as post-operative prostatectomy and diabetes. Psychogenic erectile dysfunction does not warrant coverage for penile implants.

External Prosthetic Appliances

The initial purchase and fitting of external prosthetic devices ordered or prescribed by a Participating Physician which are used as a replacement or substitute for a missing body part and are necessary for the alleviation or correction of illness, injury or congenital defect.

External prosthetic devices shall include;

- Hearing aids;
- Basic limb prosthetics;
- Terminal devices such as a hand or hook;
- Braces and splints;
- Non-foot orthoses - only the following non-foot orthoses are covered:
    a. Rigid and semi-rigid custom fabricated orthoses,
    b. Semi-rigid pre-fabricated and flexible orthoses; and
    c. Rigid pre-fabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthotics - custom orthotics are only covered as follows:
    a. For Members with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease).
    b. When the foot orthotic is an integral part of a leg brace and it is necessary for the proper functioning of the brace.
    c. When the foot orthotic is for use as a replacement or substitute for missing parts of the foot (e.g. amputation) and is necessary for the alleviation or correction of illness, injury , or congenital defect.
    d. For Members with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positions of the foot and there is reasonable expectation of improvement.

The following are specifically excluded:

- External power enhancements or power controls for prosthetic limbs and terminal devices;
- Orthotic shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers; and
- Orthoses primarily used for cosmetic rather than functional reasons.

Coverage for replacement and repair of external prosthetic appliances is provided only when required due to reasonable wear and tear and/or anatomical change. All maintenance and repairs that result from a Member's misuse are the Member's responsibility.

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Family Planning Services (Contraception and Voluntary Sterilization)

Family planning services including: medical history; physical examination; related laboratory tests; medical supervision in accordance with generally accepted medical practice; other Medical Services; information and counseling on contraception; implanted/injected contraceptives; and, after appropriate counseling, Medical Services connected with surgical therapies (vasectomy or tubal ligation).

Home Health Services

Home health services when you:

- require skilled care;
- are unable to obtain the required care as an ambulatory outpatient; and
- do not require confinement in a hospital or Other Participating Health Care Facility.

Home health services are provided only if the Healthplan Medical Director has determined that the home is a medically appropriate and cost-effective setting. If you are a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), home health services will only be provided for you during times when there is a family member or care giver present in the home to meet your non-skilled care needs.

Home health services are those skilled health care services that can be provided during intermittent visits of two (2) hours or less by Other Participating Health Professionals. Necessary consumable medical supplies, home infusion therapy, and durable medical equipment administered or used by Other Participating Health Professionals in providing home health services are covered. Home health services do not include services of a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house. Physical, occupational, and speech therapy provided in the home are subject to the benefit limitations described under "Short-term Rehabilitative Therapy".

Hospice Services

Hospice care services which are provided under an approved hospice care program when provided to a Member who has been diagnosed by a Participating Physician as having a terminal illness with a prognosis of six months or less to live. Hospice care services include inpatient care; outpatient services; professional services of a Physician; services of a psychologist, social worker or family counselor for individual and family counseling; and home health services.

Hospice care services do not include the following:

- services of a person who is a member of your family or your dependent's family or who normally resides in your house or your dependent's house;
- services and supplies for curative or life-prolonging procedures;
- services and supplies for which any other benefits are payable under the Agreement;
- services and supplies that are primarily to aid you or your dependent in daily living;
- services and supplies for respite (custodial) care; and
- nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals.

Hospice care services are services provided by a Participating Hospital; a participating skilled nursing facility or a similar institution; a participating home health care agency; a participating hospice facility, or any other licensed facility or agency under a Medicare approved hospice care program.

A hospice care program is a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families; a program that provides palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness; and a program for persons who have a terminal illness and for the families of those persons.

A hospice facility is a participating institution or portion of a facility which primarily provides care for terminally ill patients; is a Medicare approved hospice care facility; meets standards established by the Healthplan; and fulfills all licensing requirements of the state or locality in which it operates.

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Infertility Services

Services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include approved surgical and medical treatment programs that have been established to have a reasonable likelihood of resulting in pregnancy.

The following are specifically excluded infertility services:

- infertility drugs;
- in vitro fertilization; gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT) and variations of these procedures;
- any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees);
- reversal of voluntary sterilization;

- infertility services when the infertility is caused by or related to voluntary sterilization;
- cryopreservation of donor sperm and eggs; and
- any experimental or investigational infertility procedures or therapies.

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Inpatient Services at Other Participating Health Care Facilities

Inpatient services at Other Participating Health Care Facilities including semi-private room and board; skilled and general nursing services; Physician visits; physiotherapy; speech therapy; occupational therapy; x-rays; and administration of drugs, medications, biologicals and fluids.

Internal Prosthetic/Medical Appliances

Internal prosthetic/medical appliances that are permanent or temporary internal aids and supports for non-functional body parts, including testicular implants following medically necessary surgical removal of the testicles. Medically necessary repair, maintenance or replacement of a covered appliance is covered.

Laboratory and Radiology Services

Radiation therapy and other diagnostic and therapeutic radiological procedures.

Mammograms

Mammograms for routine and diagnostic breast cancer screening as follows: a single baseline mammogram if you are age 35-39; once per every other Contract Year if you are age 40-49, or more frequently based on the recommendation of your PCP; and once per Contract Year if you are age 50 and older.

Maternity Care Services

Medical, surgical and hospital care during the term of pregnancy, upon delivery and during the postpartum period for normal delivery, spontaneous abortion (miscarriage) and complications of pregnancy.

Coverage for a mother and her newly born child shall be available for a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a cesarean section. Any decision to shorten the period of inpatient care for the mother or the newborn must be made by the attending Physician in consultation with the mother.

These maternity care benefits also apply to the natural mother of a newborn child legally adopted by you in accordance with the Healthplan adoption policies. and Arizona law.

GSA-BEN(07)AZ-A 07/02

Substance Abuse Services

Substance Abuse is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of substance abuse.

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services when required for the diagnosis and treatment of addiction to alcohol and/or drugs. The Healthplan Medical Director will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Excluded Substance Abuse Services

The following are specifically excluded from substance abuse services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this agreement;
- Counseling for occupational problems;
- Residential treatment;
- Custodial care.

GSA-BEN(08)..3 9/99

Medical Foods

Medical foods to treat inherited metabolic disorders. Metabolic disorders triggering medical food

coverage are: (a) part of the newborn screening program as prescribed by Arizona statute; (b) involve amino acid, carbohydrate or fat metabolism; (c) have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and (d) require specifically processed or treated medical foods that are generally available only under the supervision and direction of a physician, that must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

We will cover up to 50% of the cost of medical foods prescribed to treat inherited metabolic disorders covered under this contract. There is a maximum annual limit for medical foods of $5,000 which applies to the cost of all prescribed modified low protein foods and metabolic formula.

For the purpose of this section, the following definitions apply:

1. "Inherited Metabolic Disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under the newborn screening program as prescribed by Arizona statute.
2. "Medical Foods" means modified low protein foods and metabolic formula.
3. "Metabolic Formula" mean foods that are al of the following: (a) formulated to be consumed or administered enternally under the supervision of a medical doctor or doctor of osteopathy; (b) processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs; (c) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and (d) essential to a person's optimal growth, health and metabolic homeostasis.
4. "Modified Low Protein Foods" means foods that are all of the following: (a) formulated to be consumed or administered enternally under the supervision of a medical doctor or doctor of osteopathy; (b) processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein; (c) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrients requirements as established by medical evaluation; (d) essential to a person's optimal growth, health and metabolic homeostatsis.

Nutritional Evaluation

Nutritional evaluation and counseling from a Participating Provider when diet is a part of the medical management of a documented organic disease, including clinically severe morbid obesity.

Obstetrical and Gynecological Services

Obstetrical and gynecological services that are provided by qualified Participating Providers for pregnancy, well-women gynecological exams, primary and preventive gynecological care and acute gynecological conditions. For these Services and Supplies you have direct access to qualified Participating Providers; you do not need a Referral from your PCP.

Organ Transplant Services

Human organ and tissue transplant services at designated facilities throughout the United States. This coverage is subject to the following conditions and limitations.

Organ transplant services include the recipient's medical, surgical and hospital services; inpatient immunosuppressive medications; and costs for organ procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogenic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or small bowel/liver.

All organ transplant services other than cornea, kidney and autologous bone marrow/stem cell transplants must be received at a qualified or provisional CIGNA Lifesource Organ Transplant Network® facility.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ

removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary.

Organ Transplant Travel Services

Travel expenses incurred by you in connection with a pre-approved organ/tissue transplant are covered subject to the following conditions and limitations. Organ Transplant Travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a pre-approved organ/tissue transplant from a designated CIGNA Lifesource Organ Transplant Network® facility. The term recipient is defined to include a Member receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the Member receiving the transplant will include charges for:

- transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility);
- lodging while at, or traveling to and from the transplant site; and
- food while at, or traveling to and from the transplant site.

In addition to you being covered for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver.

The following are specifically excluded travel expenses:

- travel costs incurred due to travel within 60 miles of your home;
- laundry bills;
- telephone bills;
- alcohol or tobacco products; and
- charges for transportation that exceed coach class rates.

These benefits are only available when the Member is the recipient of an organ transplant. No benefits are available where the Member is a donor.

Oxygen

Oxygen and the oxygen delivery system. However, coverage of oxygen that is routinely used on an outpatient basis is limited to coverage within the Service Area. Oxygen Services and Supplies are not covered outside of the Service Area, except on an emergency basis.

Periodic Health Examinations

Periodic Health Examinations, include vision and hearing screenings provided by Primary Care Physician and are available on at least the following schedule:

Age	0-1 year	1 exam every 4 months
Age	2-5 years	1 exam every year
Age	6-40 years	1 exam every 5 years
Age	41-50 years	1 exam every 3 years
Age	51-60 years	1 exam every 2 years
Age	61 and over	1 exam every year

Additionally, Periodic Health Examinations are available to each Member within twelve (12) months after their coverage is effective.

Reconstructive Surgery

Reconstructive surgery or therapy that constitutes necessary care and treatment for medically diagnosed congenital defects and birth abnormalities for newborns, adopted children and children placed for adoption who were covered from birth, adoption or adoption placement. Additionally, reconstructive surgery or therapy to repair or correct a severe facial disfigurement or severe physical deformity (other than abnormalities of the jaw or related to TMJ disorder) provide that:

- the surgery or therapy restores or improves function or decreases risk of functional impairment; or
- reconstruction is required as a result of medically necessary, non-cosmetic surgery; or
- the surgery or therapy is performed prior to age 19 and is required as a result of the congenital

absence or agenesis (lack of formation or development) of a body part including, but not limited to: microtia, amastia, and Poland Syndrome.

Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the Healthplan Medical Director.

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Short-term Rehabilitative Therapy and Chiropractic Care Services

Short-term rehabilitative therapy that is part of a rehabilitation program, including physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting**.**

The following limitations apply to short-term rehabilitative therapy:

- Services which are considered custodial or educational in nature are not covered.
- Occupational therapy is provided only for purposes of enabling Members to perform the activities of daily living.
- Speech therapy is not covered when (a) used to improve speech skills that have not fully developed in children due to an underlying disease or malformation that prevented speech development; (b) intended to maintain speech communication; or (c) not restorative in nature.

If multiple services are provided on the same day they constitute one visit, but a separate Copayment will apply to each Participating Provider.

Services that are provided by a chiropractic Physician are not covered under this section. These services include the management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion , reduce pain and improve function.

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Chiropractic Care Services

Diagnostic and treatment services utilized in an office setting by participating chiropractic Physicians and Osteopaths. Chiropractic treatment includes the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function. For these services you have direct access to qualified participating chiropractic Physicians and Osteopaths; you do not need a Referral from your PCP.

The following are specifically excluded from chiropractic care and osteopathic services:

- Services of a chiropractor or osteopath which are not within his scope of practice, as defined by state law;
- Charges for care not provided in an office setting;
- Maintenance or preventive treatment consisting of routine, long term or non-medically necessary care provided to prevent reoccurrence or to maintain the patient's current status; and
- Vitamin therapy.

GSA-BEN(11)AZ 9/99

Vision and Hearing Screenings for Dependents

Vision and hearing screenings provided by your PCP are made available to you as described in the "Periodic Health Examination" schedule in this section.

GSA-BEN(12)AZ 9/99

Section V. Exclusions And Limitations

Exclusions

Any Services and Supplies which are not described as covered in "Section IV. Covered Services and Supplies" or in an attached Rider or are specifically excluded in "Section IV. Covered Services and Supplies" or an attached Rider are not covered under this Agreement.

In addition, the following are specifically excluded Services and Supplies:

1. Care for health conditions that are required by state or local law to be treated in a public facility.
2. Care required by state or federal law to be supplied by a public school system or school district.
3. Care for military service disabilities treatable through governmental services if the Member is legally entitled to such treatment and facilities are reasonably available.
4. Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under this Agreement.
5. Assistance in the activities of daily living, including, but not limited to, eating, bathing, dressing or other custodial or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
6. Any Services and Supplies which are experimental, investigational or unproven services.

   Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Healthplan Medical Director to be:

   - not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations; or the American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
   - the subject of review or approval by an Institutional Review Board for the proposed use;
   - the subject of an ongoing clinical trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight, except as set forth in the "Cancer Clinical Trials" provision of "Section IV. Covered Services and Supplies"; or
   - not demonstrated, through existing peer-reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
7. Cosmetic surgery or surgical procedures primarily for the purpose of altering appearance, except for necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. The exclusions include surgical excision or reformation of any sagging skin on any part of the body, including, the eyelids, face, neck, abdomen, arms, legs or buttocks; and services performed in connection with the enlargement, reduction, implantation, or change in appearance of portion of the body, including, the breast, face, lips, jaw, chin, nose, ears or genital; hair transplantation; chemical face peels or abrasion of the skin; electrolysis depilation; or any other surgical or non-surgical procedures which are primarily for the purpose of altering appearance. This does not exclude services or benefits that are primarily for the purpose of restoring normal bodily function, or surgery, which is medically necessary.
8. Orthognatic treatment/surgery, including but not limited to treatment/surgery for mandibular or maxillary prognathism, microprognathism or malocclusion, surgical augmentation for orthodontics, or maxillary constriction. However, medically necessary treatment of TMJ disorder is covered.
9. Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental x-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are

covered. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.

10. Medical and surgical services intended primarily for the treatment or control of obesity which are not Medically Necessary. Excluded services include, but are not limited to, weight reduction procedures designed to restrict your ability to assimilate food, such as gastric bypass, gastric balloons, jaw wiring, and jejunal bypass.
11. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
12. Court ordered treatment or hospitalization, unless such treatment is being sought by a Participating Physician or otherwise covered under "Section IV. Covered Services and Supplies."
13. Infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
14. Reversal of voluntary sterilization procedures.
15. Transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
16. Treatment of erectile dysfunction. However, penile implants are covered when an established medical condition is the cause of erectile dysfunction.
17. Medical and hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under the Agreement.
18. Non-medical ancillary services including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy for learning disabilities, developmental delays, autism or mental retardation.
19. Therapy to improve general physical condition including, but not limited to, routine, long term or nonmedically necessary chiropractic care and rehabilitative services which are provided to reduce potential risk factors where significant therapeutic improvement is not expected.
20. Consumable medical supplies, other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services", "Outpatient Facility Services", "Home Health Services", or “Breast Reconstruction and Breast Prostheses” sections of "Section IV. Covered Services and Supplies."
21. Private hospital rooms and/or private duty nursing unless determined to be Medically Necessary by the Healthplan Medical Director.
22. Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of illness or injury.
23. Artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs, except as provided in the "Diabetic Services and Supplies" provision of the "Covered Service and Supplies" section of the Agreement.
24. Eyeglass lenses and frames and contact lenses (except for the first pair of contacts for treatment of keratoconus or post-cataract surgery).
25. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
26. Treatment by acupuncture.
27. All non-injectable prescription drugs, non-prescription drugs, and investigational and experimental drugs, except as provided in "Section IV. Covered Services and Supplies.”
28. Routine foot care, including the paring and removing of corns and calluses or trimming of nails unless Medically Necessary.

29. Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
30. Amniocentesis, ultrasound, or any other procedures requested solely for gender determination of a fetus, unless Medically Necessary to determine the existence of a gender-linked genetic disorder.
31. Genetic testing and therapy including germ line and somatic unless determined Medically Necessary by the Healthplan Medical Director for the purpose of making treatment decisions.
32. Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the Healthplan Medical Director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
33. Blood administration for the purpose of general improvement in physical condition.
34. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
35. Cosmetics, dietary supplements, health and beauty aids and nutritional formulae. However, nutritional formulae is covered when required for:
    - The treatment of inborn errors of metabolism or inherited metabolic disease (including disorders of amino acid and organic acid metabolism); or
    - enteral feeeding for which the nutritional formulae (a) under state or federal law can be dispensed only through a physician's prescription and (b) is medically necessary as the primary source of nutrition..
36. Expenses incurred for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.

In addition to the provisions of this "Exclusions and Limitations" section, you will be responsible for payments on a fee-for-service basis for Services and Supplies under the conditions described in the "Reimbursement" provision of "Section VI. Other Sources of Payment for Services and Supplies."

Limitations

Circumstance Beyond the Healthplan's Control. To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within our control results in our facilities, personnel, or financial resources being unavailable to provide or arrange for the provisions of a basic or supplemental health service or supplies in accordance with this Agreement, we will make a good faith effort to provide or arrange for the provision of the services or supplies, taking into account the impact of the event.

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Section VI. Other Sources of Payment for Services and Supplies

Workers' Compensation

Benefits under this Agreement will not duplicate any benefit which the Member is entitled to receive under workers' compensation law. In the event the Healthplan renders or pays for health services which are covered by a workers' compensation plan or included in a workers' compensation settlement, the Healthplan shall have the right to receive reimbursement either (1.) directly from the entity which provides Member's workers' compensation coverage; or (2.) directly from the Member to the extent, if any, that the Member has received payment from such entity, as follows:

1. Where the Healthplan has directly rendered or arranged for the rendering of services the Healthplan shall have a right to reimbursement to the extent of the Prevailing Rates for the care and treatment so rendered.
2. Where the Healthplan does not render services but pays for those services which are within the scope of the "Covered Services and Supplies" section of the Agreement. The healthplan shall have a right of reimbursement to the extent that the Healthplan has made payments for the care and treatment so rendered.

In addition, it is the Member's obligation to fully cooperate with any attempts by the Healhplan to recover such expenses against the Member's employer in the event that coverage is not available as a result of the failure to the employer to take the steps required by law or regulation in connection with such coverage.

Medicare Benefits

Except as otherwise provided by federal law, the services and benefits under this Agreement for Members age sixty-five (65) and older, or for Members otherwise eligible for Medicare payments, shall not duplicate any services or benefits to which such Members are eligible under Parts A or B of the Medicare Act. Where Medicare is the responsible payor, all amounts payable pursuant to the Medicare program for services and benefits provided hereunder to Members are payable to and shall be retained by the Healthplan. Members enrolled in Medicare shall cooperate with and assist the Healthplan in its efforts to obtain reimbursement from Medicare or the Member in such instances.

Coordination of Benefits

This section applies if you are covered under another plan besides this health plan and determines how the benefits under the plans will be coordinated. If you are covered by more than one health benefit plan, you should file all claims with each plan.

A. Definitions

For the purposes of this section, the following terms have the meanings set forth below them:

Plan

Any of the following that provides benefits or services for medical care or treatment:

- Group insurance and/or group-type coverage, whether insured or self-insured, which neither can be purchased by the general public nor is individually underwritten, including closed panel coverage;
- Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies;
- Medical benefits coverage of group, group-type, and individual automobile contracts.

Each type of coverage you have in these three (3) categories shall be treated as a separate Plan. Also, if a Plan has two parts and only one part has coordination of benefit rules, each of the parts shall be treated as a separate Plan.

Closed Panel Plan

A Plan that provides health benefits primarily in the form of services through a panel of employed or contracted providers and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays its benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines and may reduce its benefits after taking into consideration the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover the Reasonable Cash Value of any services it provided to you from the Primary Plan.

Allowable Expense

A necessary, customary, and reasonable health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you; but not including dental, vision or hearing care coverage. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

A plan which takes Medicare or similar government benefits into consideration when determining the application of its coordination of benefits provision does not expand the definitions of an Allowable Expense.

Claim Determination Period

A calendar year, but it does not include any part of a year during which you are not covered under this Agreement or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

B. Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

1. The Plan that covers you as a Subscriber or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
2. If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as a Subscriber or employee;
3. If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
   a. first, if a court decree states that one parent is responsible for the child's health care expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
   b. Then, the Plan of the parent with custody of the child;
   c. Then, the Plan of the spouse of the parent with custody of the child;
   d. Then, the Plan of the parent not having custody of the child, and
   e. Finally, the Plan of the spouse of the parent not having custody of the child.
4. The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan and the Plan that covers you as a laid-off or retired employee (or as that employee's Dependent) shall be the Secondary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
5. The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
6. If one of the Plans that covers you is issued out of the state whose laws govern this Agreement and determines the order of benefits based upon the gender of a parent,

and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

C. Effect on the Benefits of this Agreement

If we are the Secondary Plan, we may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than one hundred (100%) percent of the total of all Allowable Expenses.

The difference between the benefit payments that we would have paid had we been the Primary Plan and the benefit payments that we actually paid as the Secondary Plan shall be recorded as a benefit reserve for you. We will use this benefit reserve to pay any Allowable Expense not otherwise paid during the Claim Determination Period.

As to each claim that is submitted, we shall determine the following:

1. Our obligation to provide Services and Supplies under this Agreement;
2. Whether a benefit reserve has been recorded for you; and
3. Whether there are any unpaid Allowable Expenses during the Claim Determination Period.

If there is a benefit reserve, we shall use the benefit reserve recorded for you to pay up to one hundred (100%) percent of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve shall return to zero (0) and a new benefit reserve shall be calculated for each new Claim Determination Period.

D. Recovery of Excess Benefits

If we provide Services and Supplies that should have been paid by the Primary Plan or if we provide services in excess of those for which we are obligated to provide under this Agreement, we shall have the right to recover the actual payment made or the Reasonable Cash Value of any services.

We shall have the sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments were made; any insurance company; health care Plan or other organization. If we request, you shall execute and deliver to us such instruments and documents as we determine are necessary to secure its rights.

E. Right to Receive and Release Information.

We, without consent of or notice to you, may obtain information from and release information to any Plan with respect to you in order to coordinate your benefits pursuant to this section. You shall provide us with any information we request in order to coordinate your benefits pursuant to this section.

F. Injuries Covered under Med Pay Insurance

If you are injured as a result of a motor vehicle accident, and the medical expenses are covered in full or part by a medical payment provision under an automobile insurance policy (Med Pay Insurance), the Med Pay Insurance shall pay first, and the Healthplan shall pay only in the event the amount of Med Pay Insurance is insufficient to pay for those medical expenses. The Healthplan reserves the right to require proof that Med Pay Insurance has paid the full amount required prior to making any payments. Payment for such services and benefits shall be your responsibility. If the Healthplan paid in excess of their obligation, you may be asked to assist the Healthplan in obtaining reimbursement from Med Pay Insurance for expenses incurred in treating your injuries.

G. Statutory Liens

Arizona law prohibits Participating Providers from charging you more than the applicable Copayment or other amount you are obligated to pay under this Agreement for covered services. However, Arizona law also entitles certain Participating Providers to assert a lien for their customary charges for the care

and treatment of an injured person upon any and all claims of liability or indemnity, except health insurance. This means that if you are injured and have a claim against a non-health liability insurer (such as automobile or homeowner insurance) or any other payor source for injuries sustained, a Participating Provider may be entitled to a lien against available proceeds from any such insurer or payor in an amount equal to the difference between: (1) the applicable Member Copayment plus what the Participating Provider has received from Healthplan as payment for covered services, and (2) the Participating Provider's full billed charges.

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Section VII. Termination of Your Coverage

We may terminate your coverage for any of the reasons stated below.

Termination By Reason of Ineligibility

When you fail to meet the eligibility criteria in "Section II. Enrollment and Effective Date of Coverage" as either a Subscriber or Dependent, your coverage under this Agreement shall cease. Coverage of all Members within a Membership Unit shall cease when the Subscriber fails to meet the eligibility criteria. The Group shall notify us of all Members who fail to meet the eligibility criteria.

Unless otherwise provided by law, if you fail to meet the eligibility criteria your coverage shall cease at midnight of the day that the loss of eligibility occurs, and we shall have no further obligation to provide Services and Supplies.

Termination By Termination of This Agreement

This Agreement may be terminated for any of the following reasons:

1. Termination for Non-Payment of Fees. We may terminate this Agreement for the Group's non-payment of any Prepayment Fees owed to us.
2. Termination on Notice. The Group, without cause, may terminate this Agreement upon sixty (60) days prior written notice to us. We, without cause, may terminate this Agreement upon either: (i) ninety (90) days prior written notice to the Group of our decision to discontinue offering this particular type of coverage; or (ii) at the renewal date of the plan upon one hundred eighty (180) days prior written notice to the Group of our decision to discontinue offering all coverage in the applicable market. If coverage is terminated in accordance with (i) above, the Group may purchase a type of coverage currently being offered in that market.
3. Termination for Fraud or Misrepresentation. We may terminate this Agreement upon thirty (30) days prior written notice to the Group if, at any time, we determine that the Group has performed an act or practice that constitutes fraud or has intentionally misrepresented a material fact.
4. Termination for Violation of Contribution or Participation Rules. We may terminate this Agreement upon sixty (60) days prior written notice to the Group if, after the initial twelve (12) month or other specified time period, it is determined that the Group is not in compliance with the participation and/or contribution requirements as established by us.
5. Termination Due to Association Membership Ceasing. If this Agreement covers an association, we may terminate this Agreement in accordance with applicable state or federal law as to a member of a bona fide association if the member is no longer a member of the bona fide association.

Termination Effective Date. Coverage under this Agreement shall terminate at midnight of the date of termination provided in the written notice, except in the case of termination for non-payment of fees, in which case this Agreement shall terminate immediately upon our notice to the Group.

Notice of Termination to Members. If this Agreement is terminated for any reason by CIGNA, and is not replaced by any other health coverage, we will notify you of the termination effective date. The Group will notify you of any applicable rights you may have under "Continuation of coverage" section.

Responsibility for Payment. The Group shall be responsible for the payment of all Prepayment Fees due through the date on which coverage ceases. You shall be financially responsible for all services rendered after that date. The Group shall be responsible for providing appropriate notice of cancellation to all Members in accordance with applicable state law. If the Group fails to give written notice to you prior to such date, the Group shall also be financially responsible for, and shall submit to us, all Prepayment Fees due until such date as the Group gives proper notice.

Certification of Creditable Coverage Upon Termination

We will issue you a Certification of Group Health Plan Creditable Coverage as required by law and based on information provided to us by the Group at the following times:

1. When your coverage is terminated for cause or by reason of ineligibility or you otherwise become covered under "Section VIII. Continuation of Coverage";
2. When your continuation coverage, if you elected to receive it, is exhausted; and
3. When you make a request within twenty-four (24) months after the date coverage expires under either of the above two situations.

Section VIII. Continuation of Coverage

Continuation of Group Coverage under COBRA

Under the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), an employer must give its employees and dependents the right to continue their group health care benefits. A person who would otherwise lose coverage as a result of a qualifying event is generally entitled to continue the same benefits that were in effect the day before the date of the qualifying event. Coverage may be continued under COBRA only if the required premiums are paid when due and will be subject to future plan changes.

A **qualifying event** is any of the following:

- termination of the Subscriber's employment (other than for gross misconduct) or reduction of hours worked so as to render the Subscriber ineligible for coverage;
- death of the Subscriber;
- divorce or legal separation of the Subscriber from his or her spouse;
- loss of coverage due to the Subscriber becoming entitled to Medicare;
- a Dependent child ceasing to qualify as an eligible Dependent under the plan; or
- if the plan provides coverage for retired Subscribers and eligible Dependents, a qualifying event will also mean a substantial loss of that coverage due to the employer filing for Chapter 11 Bankruptcy. (The substantial loss can occur within one year before or after the filing for Chapter 11 Bankruptcy.)

When there is a divorce or legal separation or a child ceases to qualify as an eligible Dependent, the Subscriber or eligible Dependent is responsible for notifying the employer within 60 days after the date of such qualifying. If the employer is not so notified, the person will not be given the opportunity to continue coverage.

After notification of his or her COBRA rights, the Subscriber or eligible Dependent has a limited amount of time to elect continuation. Continued health care is not automatic.

Continuation of COBRA benefits must be elected within 60 days of the later of the following:

- the date the Subscriber or eligible Dependent loses coverage as a result of the qualifying event; or
- the date the Subscriber or eligible Dependent is notified by the employer of the right to continued coverage.

Notice of the right to continue coverage to your spouse will be deemed notice to any Dependent child residing with your spouse.

The Subscriber or eligible Dependent may be required to pay a premium to continue coverage. If the Subscriber or eligible Dependent elects to continue coverage, the Subscriber or eligible Dependent will have 45 days from the date of election to pay the initial premium due. All subsequent premiums will be due on a monthly basis. There is a 30 day grace period to pay premiums. If the premium is not paid before the expiration of the grace period, COBRA continuation benefits will end.

If elected, the maximum period of continued coverage for a qualifying event involving termination of employment or reduced working hours is 18 months from the date of the qualifying event. However, if a second qualifying event occurs (such as a divorce or death of the Subscriber) within this 18 month period, the period of coverage for any affected Dependent may be extended to up to 36 months from the date of the initial qualifying event.

If a qualified beneficiary is totally disabled under the Social Security Act on the date of the qualifying event, or at any time during the first 60 days of continued coverage, the 18 month period may be extended to up to 29 months. If there are non-disabled family members of this qualified beneficiary who have elected COBRA continuation coverage, they are also entitled to this additional 11 months of coverage. In order for this additional 11 months of coverage to be effective, the Subscriber or eligible Dependent must provide the employer with a copy of the Social Security Administration's determination of total disability within 60 days of receiving such notice. The notice must also be provided to the employer within the initial 18 months of COBRA continuation coverage.

If a covered Subscriber has a qualifying event (termination of employment or reduction in hours worked) and he/she had become entitled to Medicare before the date of this qualifying event, then

- the Subscriber may continue the group health coverage for up to 18 months from the date of termination or reduction in hours worked, and
- any other qualified beneficiary (the spouse and/or children) will be entitled to the greater of (i) 36 months from the date the Subscriber first became entitled to Medicare, or (ii) 18 months from the covered Subscriber's termination or reduction in hours.

The maximum period of continued benefits for a qualifying event involving retired Subscribers of employers under Chapter 11 Bankruptcy and their Dependents will be:

- the date of death of the retired Subscriber; or
- for a surviving spouse or eligible Dependent, 36 months after the date of death of the retired employee.

For all other qualifying events, the maximum period is 36 months, except as provided below.

If the employer provides continuation options in addition to COBRA, the Subscriber or eligible Dependent may elect one of them in lieu of COBRA, but the Subscriber or eligible Dependent may not have both. The election of another continuation option is a waiver of COBRA.

However, if the Plan provides for continuation of existing coverage for a certain period of time after any qualifying event, the Subscriber may receive a COBRA election form when the existing coverage actually ends. The Subscriber or eligible Dependent may elect COBRA continuation coverage for the balance of the 18, 29 or 36 month period.

Other events will cause COBRA benefits to end sooner and this will occur on the earliest of any of the following:

- the date the employer ceases to provide any group health plan to any employee;
- the date the Subscriber or eligible Dependent fails to timely pay any required premium payment;
- the first day after the date of election on which the qualified beneficiary first becomes covered under any other group health plan which does not contain any exclusions or limitations with respect to any pre-existing condition for such person; or the date such exclusion or limitation no longer applies to the Subscriber or Dependent;
- the first day after the date of election on which the qualified beneficiary first becomes entitled to Medicare (except for a Chapter 11 Bankruptcy qualifying event); or
- with respect to a qualified beneficiary whose coverage is being extended for the additional 11 months as described above, coverage will terminate on the first day of the month that is more than 30 days after the date in which the disabled individual is no longer disabled for Social Security purposes.

If the plan provides for a conversion privilege, the plan must offer this option within the 180 days of the end of the maximum period. However, no conversion will be provided if the qualified beneficiary does not actually maintain COBRA coverage to the expiration date.

IMPORTANT NOTICE - COBRA BENEFITS WILL ONLY BE ADMINISTERED ACCORDING TO THE TERMS OF THE CONTRACT. THE HEALTHPLAN WILL NOT BE OBLIGATED TO ADMINISTER, OR FURNISH, ANY COBRA BENEFITS AFTER THE CONTRACT HAS TERMINATED.

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Conversion to Non-Group (Individual) Coverage

If you do not elect COBRA continuation coverage, fail to properly elect COBRA continuation coverage, are ineligible to elect COBRA continuation coverage, or had COBRA continuation coverage for which the maximum coverage period has expired, you may apply to the Healthplan for conversion to non-group (individual) coverage. You must continue to reside in the Service Area in order to be eligible for non-group (individual) coverage. You may apply for non-group (individual) coverage as follows:

A. Conversion After Loss of Subscriber Eligibility

If you, as the Subscriber, are no longer eligible for coverage under this Agreement for any reason other than the reasons stated in the "Termination of Agreement" provisions of "Section VII. Termination of Your Coverage," you may apply for conversion to non-group (individual) coverage. You must apply and pay the applicable Prepayment Fee within thirty-one (31) days of the loss of group coverage. At the time of conversion to non-group (individual) coverage, you may also apply for non-group (individual) coverage for Dependents who were Members at the time of your loss of eligibility. If your application and all non-group fees, including all fees for the period since the termination of group coverage, are submitted within thirty-one (31) days of the loss of group coverage your non-group (individual) coverage will be effective as of the date of such termination.

B. Conversion Upon Death or Divorce of Subscriber

If you are a Dependent who has lost eligibility for coverage under this Agreement due to the death or divorce of the Subscriber, you may apply for conversion to non-group (individual) coverage under the provisions of paragraph A of this section.

C. Conversion Upon Meeting Age Limitation

If you are a Dependent who has lost eligibility for coverage under this Agreement due to your attainment of an age limitation identified in the Agreement, you may apply for conversion to non-group (individual) coverage under the provisions of paragraph A of this section.

D. Conversion After Expiration of COBRA Continuation Coverage

A Member whose COBRA continuation coverage has expired after the maximum coverage period may apply for conversion to non-group (individual) coverage under the provisions of paragraph A of this section.

The Services and Supplies, terms and conditions of the non-group (individual) coverage, including premiums, Copayments and deductibles, if any, shall be in accordance with the rules of Healthplan in effect at the time of conversion and will not necessarily be identical to the Services and Supplies provided under this Agreement.

Continuation of Coverage Under FMLA

If the Group is subject to the requirements of FMLA (the federal law known as the Family and Medical Leave Act of 1993, as amended), the Subscriber shall have coverage under this Agreement during a leave of absence if the Subscriber is an eligible employee under the terms of FMLA and the leave of absence qualifies as a leave of absence under FMLA.

In such a case, the Subscriber shall pay to the Group the portion of the Prepayment Fee, if any, that the Subscriber would have paid had the Subscriber not taken leave and the Group shall pay the Healthplan the Prepayment Fee for the Subscriber as if the Subscriber had not taken leave.

Section IX. Miscellaneous

Additional Programs

We may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to our Members for the purpose of promoting the general health and well being of our Members. Contact the Healthplan Member Services for a list of currently available programs, participating businesses, and other details regarding such arrangements. These programs may include discounts on the following types of services:

- Health Club/GYM Memberships
- Tai-Chi Classes
- Weight Loss Program
- Alternative Care, including Massage Therapy
- Health Food Stores
- Over the Counter Medications
- Vision Products and Services
- Hearing Aids and Services
- Wellness Classes-Selected classes may be offered to our Members for a copayment at participating CIGNA HealthCare Centers
- CIGNA HealthCare Healthy Babies Program®

These programs are provided for the benefit of CIGNA HealthCare Members, and are not an endorsement of the services or vendors listed. Discounts are subject to change or elimination upon sixty (60) days' prior notice.

Administrative Policies Relating to this Agreement

We may adopt reasonable policies, procedures, rules and interpretations that promote orderly administration of this Agreement.

Assignability

The benefits under this Agreement are not assignable unless agreed to by the Healthplan. The Healthplan may, at its option, make payment to the Subscriber for any cost of any covered Services and Supplies received by the Subscriber or Subscriber's covered dependents from a non-participating provider. The Subscriber is responsible for reimbursing the non-participating provider.

Clerical Error

No clerical error on the part of the Healthplan shall operate to defeat any of the rights, privileges or benefits of any Member.

Entire Agreement

This Agreement constitutes the entire Agreement between the Healthplan, the Group, and Members and supersedes any previous agreement. Only an officer of the Healthplan has authority to waive any conditions or restrictions of this Agreement, extend the time for making payment, or bind the Healthplan by making any promise or representation, or by giving or receiving any information. No change in the Agreement shall be valid unless stated in a Rider or an amendment attached hereto signed by an officer of the Healthplan. In the event of any direct conflict between information contained in the Group Service Agreement and other collaterals, the terms of the Group Service Agreement shall govern.

No Implied Waiver

Failure by the Healthplan, the Group, or a Member to avail themselves of any right conferred by this Agreement shall not be construed as a waiver of that right in the future.

Notice

The Healthplan, the Group, and the Member shall provide all notices under this Agreement in writing, which shall be hand-delivered or mailed, postage pre-paid, through United States Postal Service to the addresses set forth on the Cover Sheet.

Records

The Healthplan maintains records regarding Members, but the Healthplan shall not be liable for any obligation dependent upon information from the Group prior to receipt by the Healthplan in a form satisfactory to the Healthplan. Incorrect information furnished by the Group may be corrected, if the Healthplan shall not have acted to its prejudice by relying on it. All records of the Group and the Healthplan that have a bearing on coverage of a Member shall be open for review by the Healthplan, the Group or the Member at any reasonable time.

Service Marks

The CIGNA HealthCare 24 Hour Health Information Line [SM] and CIGNA Lifesource Organ Transplant Network® are registered service marks of CIGNA Corporation.

Severability

If any term, provision, covenant or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of this Agreement shall remain in full force and effect and shall in no way be affected, impaired, or invalidated.

Successors and Assigns

This Agreement shall be binding upon and shall inure to the benefit of the successors and assigns of the Group and the Healthplan, but shall not be assignable by any Member.

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Schedule of Copayments

THIS SCHEDULE OF COPAYMENTS IS A SUPPLEMENT TO THE GROUP SERVICE AGREEMENT PROVIDED TO YOU AND IS NOT INTENDED AS A COMPLETE SUMMARY OF THE SERVICES AND SUPPLIES COVERED OR EXCLUDED.

It is recommended that you review your Group Service Agreement for an exact description of the Services and Supplies that are covered, those which are excluded or limited, and other terms and conditions of coverage.

Covered Services and Supplies	Copayments
Physician Services	
Primary Care Physician Office Visit Preventive Care Adult Medical Care Periodic Physical Evaluation for Adults Well-Child Care Routine Immunizations and Injections Surgery Performed in the Physician's Office	$35 Copayment per office visit The office visit Copayment will be waived when immunization is the only service provided
Specialty Care Physician Office Visit Office Visits Surgery Performed in the Physician's Office	$50 Copayment per office visit
Inpatient Hospital Services Semi Private Room and Board Physician and Surgeon Charges Laboratory, Radiology and other Diagnostic and Therapeutic Services Administered Drugs, Medications, Biologicals and Fluids Special Care Units Operating Room, Recovery Room Anesthesia Inhalation Therapy Radiation Therapy and Chemotherapy	$1,000 Copayment and 10% per admission
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, and Treatment Room including Physician Services Laboratory and Radiology Services Administered Drugs, Medications, Biologicals and Fluids Anesthesia Inhalation Therapy	$500 Copayment and 10% per facility use

Schedule of Copayments

Covered Services and Supplies	Copayments
Emergency and Urgent Care Services	
Physician's Office	Same as Physician Office Visit Copayment
Hospital Emergency Room or Outpatient Facility	$150 Copayment per visit The emergency room Copayment will be waived if you are admitted to a participating hospital directly from the emergency room
Urgent Care Facility	$75 Copayment per visit
Ambulance Services	No Charge
Diabetic Services and Supplies	
Self Management Courses and Training	Same as Physician Office Visit Copayment
Equipment	Same as Durable Medical Equipment Copayment per item
Insulin and other Diabetic Pharmaceutical Supplies	$10 Copayment per item/per prescription
Durable Medical Equipment $3,500 maximum per Member per Contract Year; except that Equipment related to the treatment of Diabetes is not subject to a dollar maximum.	No Charge
External Prosthetic Appliances $200 deductible per Member per Contract Year. $1,000 maximum per Member per Contract Year. Hearing Aids $2,200 maximum every three contract years. The deductible does not apply.	No Charge after the deductible
Family Planning Services	
Office Visits (Tests, Counseling)	Same as Physician Office Visit Copayment
Surgical Sterilization Procedures	Same as Inpatient Hospital, Outpatient Facility or Physician Office Visit Copayment, depending on facility used

Schedule of Copayments

Covered Services and Supplies	Copayments
Home Health Services 60 day maximum per member per contract year. Maximum of 16 hours in total per day	No Charge
Hospice Services	
Inpatient Services	10% Copayment
Outpatient Services	No Charge
Infertility Services	
Physician Office Visit	Same as Physician Office Visit Copayment
Surgical Treatment	50% Copayment per procedure
Inpatient Services at Other Participating Health Care Facilities 90 day maximum per Member per Contract Year	
Rehabilitation Hospital	10% Copayment
Skilled Nursing Facility and Sub-Acute Facilities	10% Copayment
Laboratory and Radiology Services	
Advanced Radiological Imaging (MRIs, MRAs, CAT scans, PET scans, etc.)	$200 Copayment
Other Laboratory and Radiology Services	No Charge
Mammography	Same as Inpatient Hospital, Outpatient Facility or Physician Office Visit Copayment depending on facility used
Maternity Care Services	
Initial Office Visit to Confirm Pregnancy	Same as Physician Office Visit Copayment
All other Office Visits	No Charge
Delivery	Same as Inpatient Hospital Copayment

Schedule of Copayments

Covered Services and Supplies	Copayments
Substance Abuse Services	
Inpatient Substance Abuse Detoxification Services	Same as Inpatient Hospital Copayment
Outpatient Substance Abuse Detoxification Therapy	Same as Physician Office Visit Copayment
Nutritional Evaluation 3 visit maximum per Member per Contract Year	Same as Physician's Office Visit Copayment
Transplant Travel Services Maximum $10,000 maximum benefit	
Short-term Rehabilitative Therapy Services provided on an outpatient basis are limited to a 60 visit maximum per Member per Contrac Year	$50 Copayment per office visit
Chiropractic Care Services Services provided on an outpatient basis are limited to a 20 visit maximum per Member per Contrac Year	$50 Copayment per office visit

Total Copayment Maximum *	
Individual Member Total Copayment Maximum	$5,000 per Contract Year
Membership Unit Total Copayment Maximum	$10,000 per Contract Year

Schedule of Copayments

*Only Copayments identified in this Schedule of Copayments which have been paid by a Member for Inpatient Hospital Services, Outpatient Facility Services, Inpatient Services at Other Participating Health Care Facilities, Inpatient Mental Health Services, Inpatient Substance Abuse Rehabilitation and Inpatient Detoxification Services apply to these maximums. It is the Member's responsibility to maintain a record of Copayments which have been paid, and to inform the Healthplan when the amount reaches the Total Copayment Maximum.

Note: If the Participating Provider has contracted with the Healthplan to receive payment on a basis other than fee-for-service amount, then your percent Copayment will be calculated based on a Healthplan-determined fee schedule amount or Healthplan-determined percentage of actual billed charges.

Alternative Medical Services Benefit

This Supplemental Rider is a part of the CIGNA HealthCare of Arizona, Inc. Group Service Agreement (the Agreement) and subject to all of the terms, conditions and limitations contained therein. In consideration for an additional monthly fee incorporated into the Prepayment fee, the following supplemental benefit for Alternative Medical Services are added to the Agreement.

I. Definitions

a. **Alternative Medical Services** means services, treatments or products not performed, practiced or provided within the practice of standard medicine.

b. **Designated Alternative Medicine Center** means a facility or Physician qualified to provide certain Alternative Medical Services who is specifically designated by the HEALTHPLAN Medical Director to provide those services.

II. Services and Benefits

Coverage will be provided for certain outpatient Alternative Medical Services received from a Designated Alternative Medicine Center or other Participating Health Professional which are considered to be appropriate options to standard medical intervention. Coverage will also be provided for herbal or homeopathic products available at or through a Designated Alternative Medicine Center. Services for a Member may be authorized by a Participating Physician, or the Member may obtain the services from a Designated Alternative Medicine Center without authorization for up to ten (10) visits per Contract Year.

a. Outpatient Alternative Medical Services. Covered Services include only the following services: Physician assessment, acupuncture, acupressure, physical medicine, guided imagery, massage therapy, biofeedback, and such other services as may be specifically approved by the HEALTHPLAN Medical Director.

b. Herbal or Homeopathic Products. Herbal or homeopathic products which are approved by the HEALTHPLAN are covered when obtained at a Designated Alternative Medical Center. The retail cost of these Products is subject to a Contract Year maximum of $60.00.

Coverage provided under this Rider shall be subject to the following Copayments:

- Office Visit - $5 Copayment per visit
- Herbal and Homeopathic Products - No Charge

III. Exclusions

Except as otherwise set forth in this Rider, coverage is subject to the exclusions and limitations set forth in the Exclusions and Limitations Section of the Agreement.

ALTMED-AZ Maricopa 1/05

Out-of-Network Certificate

The benefits described in the pages to follow are underwritten by Connecticut General Life Insurance Company.

Home Office: Bloomfield, Connecticut
Mailing Address: Hartford, Connecticut 06152

CONNECTICUT GENERAL LIFE INSURANCE COMPANY
a CIGNA company (called CG) certifies that it insures certain Employees for the benefits provided by the following policy:

POLICYHOLDER: FIRST SECURITY BANK OF UTAH
AS TRUSTEE OF THE HEALTH
ACCESS INSURANCE TRUST

GROUP POLICY(S) - COVERAGE

MEDICAL EXPENSE INSURANCE

This certificate describes the main features of the insurance. It does not waive or alter any of the terms of the policy(s). If questions arise, the policy(s) will govern.

This certificate takes the place of any other issued to you on a prior date which described the insurance.

Susan L. Cooper

Corporate Secretary

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Notice of Federal Requirements

COVERAGE FOR RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

When a person insured for benefits under this certificate who has had a mastectomy at any time, decides to have breast reconstruction, based on consultation between the attending Physician and the patient, the following benefits will be subject to the same coinsurance and deductibles which apply to other plan benefits:

- surgical services for reconstruction of the breast on which the mastectomy was performed;
- surgical services for reconstruction of the non-diseased breast to produce a symmetrical appearance;
- post-operative breast prostheses; and
- mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic replacement needs.

During all stages of mastectomy, treatment of physical complications, including lymphedema therapy are covered.

If you have any questions about your benefits under this Plan, please call the number on your ID card or contact your Employer.

MATERNITY HOSPITAL STAY

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable. Please review this Plan for further details on the specific coverage available to your and your Dependents.

Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

The Schedule

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section.

Schedule of Out-of-Network Medical Benefits

For You and Your Dependents

Covered Expenses	Payments
Lifetime Maximum	$1,000,000
Individual Out-of-Pocket Maximum	$10,000
Family Out-of-Pocket Maximum (See section entitled "Full Payment Area")	$20,000
Major Medical Deductible	
Individual	$1,000
Family After Major Medical Deductibles totaling **the amount shown at right** have been applied in a Contract Year for either (a) you and your Dependents or (b) your Dependents, any Medical Deductible will be waived for your family for the rest of that Contract Year.	$2,000
Benefit Percentage for Covered Expenses incurred for:	
Inpatient Hospital	70% after $2,000 per Admission Deductible and Major Medical Deductible
Outpatient Facility	70% after $1,000 per Admission Deductible and Major Medical Deductible
Durable Medical Equipment	Not Covered
External Prosthetic Appliances	Not Covered
Home Health Care Maximum 40 days per Contract Year	70% after Major Medical Deductible

Laboratory and Radiology Services	
Advanced Radiological Imaging (MRIs, MRAs, CAT scans, PET scans etc.)	70% after Major Medical Deductible
Other Laboratory and Radiology Services	70% after Major Medical Deductible
Mental Health and Substance Abuse Services	Not Covered
Substance Abuse Detoxification Services	
Inpatient	70% after Major Medical Deductible
Outpatient	70% after Major Medical Deductible
Short-term Rehabilitation Therapy Maximum Services provided on an outpatient basis are limited to a 60 visit maximum per Contract Year	70% after Major Medical Deductible
Prescription Drugs	Not Covered
Skilled Nursing Facility Maximum 90 days per Contract Year	70% after Major Medical Deductible
All Other Covered Expenses	70% after Major Medical Deductible

The day limits, visit limits and dollar maximums (other than Out-of-Pocket Maximums) shown in this Schedule will be reduced by the number of days, visits or equivalent dollar amounts for which you receive Basic Benefits in the same Contract Year.

Medical Care Benefits For You and Your Dependents

Pre-Admission Certification/Continued Stay Review Requirements

Pre-Admission Certification (PAC) and Continued Stay Review (CSR) refer to the process used to certify the medical necessity and length of any Hospital Confinement as a registered bed patient. PAC and CSR are performed through a utilization review program by a Review Organization with which CG has contracted. PAC should be requested by you or your Dependent for each inpatient Hospital admission. CSR should be requested, prior to the end of the certified length of stay, for continued inpatient Hospital Confinement.

Expenses incurred for which benefits would otherwise be payable under this plan for the Hospital charges listed below will be reduced by 50% for:

- any Hospital charges made during any Hospital Confinement as a registered bed patient unless PAC is received: (a) prior to the date of admission; or (b) in the case of an emergency admission, by the end of the first scheduled work day after the date of admission.

Expenses incurred for which benefits would otherwise be payable under this plan will not include:

- Hospital charges for Bed and Board, during a Hospital Confinement for which PAC is performed, which are made for any day in excess of the number of days certified through PAC or CSR; and
- any Hospital charges made during any Hospital Confinement as a registered bed patient: (a) for which PAC was performed; but (b) which was not certified as medically necessary.

GM6000 SC1 PAC1 Maricopa CHA (1/05)

In any case, those expenses incurred for which payment is excluded by the terms set forth above will not be considered as expenses incurred for the purpose of any other part of this plan, except for the "Coordination of Benefits" section.

You should start the PAC process by calling the Review Organization prior to an elective admission, or in the case of an emergency admission, by the end of the first scheduled work day after the admission. For an admission due to pregnancy, you should call the Review Organization by the end of the third month of pregnancy. The Review Organization will continue to monitor the confinement until you are discharged from the Hospital. The results of the review will be communicated to you, the attending Physician, the Hospital, and CG.

The Review Organization is an organization with a staff of Registered Graduate Nurses and other trained staff members who perform the PAC and CSR process in conjunction with consultant Physicians.

Pre-authorization Requirement

Prior-authorization should be requested by you or your Dependent at least 14 days prior to the performance of diagnostic or surgical services performed at an Outpatient Surgical Facility and for magnetic resonance imaging.

Amounts for expenses incurred, which would otherwise be payable under this plan, will be reduced by 50% for services described above for which pre-authorization was not obtained.

GM6000 SC1 PAC2 Maricopa CHA (1/05)

How to File Your Claim

The prompt filing of any required claim form will result in faster payment of your claim.

You may get the required CG claim forms from CIGNA HealthCare. All fully completed claim forms and bills should be filed through CIGNA HealthCare.

Depending on your Group Insurance Plan benefits, file your claim forms as described below.

Hospital Confinement

If possible, get your Group Medical Insurance claim form from CIGNA HealthCare before you are admitted to the Hospital. This form will make your admission easier and any cash deposit usually required will be waived.

Doctor's Bills and Other Medical Expenses

The first Medical Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

CLAIM REMINDERS

- BE SURE TO USE YOUR SOCIAL SECURITY NUMBER WHEN YOU FILE CG'S CLAIM

FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE.

- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

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GM6000 CI 3 CLA9V2 M

Who is Eligible

For Employee Insurance

You will become eligible for insurance on the later of:

- your Employer's Participation Date; or
- the date you become a member of a Class of Eligible Employees.

For Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

CLASSES OF ELIGIBLE EMPLOYEES

Each Employee who is enrolled for Basic Benefits.

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GM6000 EL 2 ELI71 M

Eligibility – Effective Date

Employee Insurance

This plan is offered to you as an Employee. To be insured, you may have to pay part of the cost.

Effective Date of Your Insurance

You will become insured on the date you become eligible; provided you have agreed to make the required contribution toward the cost of Employee Insurance, if any, by signing an approved payroll deduction form.

GM6000 EF 1 ELI7 M

Dependent Insurance

For your Dependents to be insured, you may have to pay part of the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you become eligible for Dependent Insurance for that Dependent; provided you have agreed to make the required contribution toward the cost of that insurance, if any, by signing an approved payroll deduction form. All of your Dependents, as defined, who are enrolled for Basic Benefits will be included.

Your Dependents will be insured only if you are insured.

Exception for Newborns

Any Dependent child born while you are insured for Dependent Insurance will be insured from his date of birth.

Any Dependent child born while you are insured for Medical Insurance for yourself, but not for your Dependents, will become insured for Medical Insurance on the date of his birth if you elect Dependent Medical Insurance no later than 31 days after his birth.

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GM6000 EF 2 ELI11 M

Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA'93)

These health coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income.

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, where applicable.

A. Eligibility for Coverage under a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child within 31 days of the court order being issued.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or state agency, and satisfies all of the following:

1. the order specifies your name and last known address, and the child's name and last known address;
2. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
3. the order states the period to which it applies; and
4. the order specifies each plan that it applies to.

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit not otherwise provided under the policy.

GM6000 EF 3 ELI98V20

B. Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

The provisions in the "Exceptions for Newborns" section of this certificate that describe requirements for enrollment and effective date of insurance will also apply to an adopted child or a child placed with you for adoption.

Any "Pre-existing Condition Limitation" in this certificate will be waived for an adopted child or a child placed for adoption.

GM6000 EF 3 ELI98V21

Major Medical Benefits For You and Your Dependents

If you or any one of your Dependents, while insured for these benefits, incurs Covered Expenses, CG will pay an amount determined as follows:

The Benefit Percentage of Covered Expenses incurred as shown in The Schedule, if any, provided that: (1) the Hospital Deductible shown in The Schedule will first be deducted from the Covered Expenses incurred for charges made by a Hospital for each separate admission as a registered bed patient; (2) the Skilled Nursing Facility Deductible shown in The Schedule, if any, will first be deducted from the Covered Expenses incurred for charges made by a Skilled Nursing Facility for each separate confinement in a Skilled Nursing Facility; and (3) the Major Medical Deductible shown in The Schedule will first be deducted from all other Covered Expenses incurred for a person in each Contract Year.

Payment of any benefits will be subject to the Maximum Benefit Provision.

Full Payment Area

When the amount of Covered Expenses incurred by a person in a Contract Year for which no payment is provided because of Coinsurance, exclusive of any deductible, equals the Individual Out-of-Pocket Control shown in The Schedule, benefits for him for Covered Expenses incurred during the rest of that Contract Year will be payable at the rate of 100%.

When the combined amount of Covered Expenses incurred in a Contract Year by you and at least one of your Dependents or at least two of your Dependents for which no payment is provided because of Coinsurance, exclusive of any deductible, equals two times the Individual Out-of-Pocket Control shown in The Schedule, benefits for you and all of your Dependents for Covered Expenses incurred during the rest of that Contract Year will become payable at the rate of 100%, subject however to any applicable deductible amount not yet satisfied by you or any of your Dependents in that Contract Year.

Any Hospital Deductible will continue to apply even though the rate at which benefits are payable changes. The Major Medical Deductible, if not yet satisfied, will continue to apply until it is satisfied.

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GM6000 MM1 MAJ1 M

Maximum Benefit Provision

The total amount of Major Medical Benefits payable for all expenses incurred for a person in his lifetime will not exceed the Maximum Benefit shown in The Schedule.

V-2
GM6000 MM2 MAJ20 M

Covered Expenses

The term Covered Expenses means expenses incurred by or on behalf of a person for the charges listed below, after he becomes insured for these benefits. Expenses incurred for such charges are considered Covered

Expenses to the extent that the services or supplies provided are recommended by a Physician and are Medically Necessary, as determined by CG, for the care and treatment of an Injury or a Sickness:

- by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies and for medical care and treatment received as an outpatient; except that, for any day of Hospital Confinement in a private room, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Hospital's most common daily rate for a semi-private room.
- by a Physician for professional services.
- by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- by a Skilled Nursing Facility, on its own behalf, for medical care and treatment; except that for any day of Skilled Nursing Facility confinement, Covered Expenses will not include that portion which is more than the Skilled Nursing Facility's most common daily rate for a semiprivate room; nor will Covered Expenses include charges for any day of confinement in excess of the Skilled Nursing Facility Maximum shown in The Schedule.

GM6000 MM3-CHA MAJ28V2 M

- for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatments; chemotherapy; blood and blood products; and physical therapy provided by a licensed physical therapist; and drugs and medicines lawfully prescribed by a Physician, excluding vitamins.
- for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- for drugs and medicines lawfully dispensed only on the written prescription of a Physician, excluding vitamins; provided that benefits for Prescription Drugs are included in your Employer’s Plan as determined from The Schedule. In any event, drugs prescribed while a person is Confined in a Hospital will be covered.

GM6000 MM31 MAJ197V291

Home Health Care Services

Charges made for Home Health Care Services when you:

- require skilled care;
- are unable to obtain the required care as an ambulatory outpatient; and
- do not require confinement in a Hospital or Other Health Care Facility.

Home Health Care Services are provided only if CG determines that the home is a medically appropriate and cost-effective setting.

Home Health Care Services are provided under the terms of a Home Health Care plan for the person named in that plan.

If you are a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), Home Health Care Services will only be provided for you during times when there is a family member or care giver present in the home to meet your non-skilled care needs.

Home Health Care Services are those skilled health care services that can be provided during intermittent visits of 2 hours or less by Other Health Care Professionals. Necessary consumable medical supplies, home infusion therapy, and Durable Medical Equipment administered or used by Other Health Care Professionals in providing Home Health Care Services are covered. Home Health Care Services do not include services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house. Physical, occupational, and speech therapy provided in the home are subject to the benefit limitations described under "Short-term Rehabilitative Therapy".

Other Health Care Facilities are facilities other than a Hospital or a Hospice Facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation hospitals and sub-acute facilities.

Other Health Care Professionals include an individual, other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services. Other Health Care Professionals include, but are not limited to physical therapists, home health aides and nurses.

GM6000INDEM2

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for, expenses incurred:

- for any services or supplies for which you or your Dependents receive Basic Benefits.
- for cosmetic surgery or therapy, unless performed for repair or correction of severe facial disfigurements or severe physical deformities that are congenital or result from developmental abnormalities (other than abnormalities of the jaw or TMJ disorder), tumors, trauma, disease or the complications of medically necessary, non-cosmetic surgery. Reconstructive surgery for correction of congenital birth defects or developmental abnormalities must be performed prior to your attainment of age 19. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement, as determined by CG.
- for eyeglasses, hearing aids or examinations for prescription or fitting thereof.
- for or in connection with treatment of the teeth or periodontium.
- for or in connection with organ transplant services including immunosuppressive medication; organ procurement costs; or donor's medical costs.
- for services provided for the management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.
- for or in connection with any procedure or treatment related to infertility such as artificial insemination, in vivo or in vitro fertilization, gamete or zygote intrafallopian transfer procedures, or similar procedures; any cost associated with the collection, preparation or storage of sperm for artificial insemination; or oral or injectible drugs which promote fertility.
- for treatment of erectile dysfunction, except when an established medical condition is the cause of penile erectile dysfunction
- for medical and surgical services intended primarily for the treatment or control of obesity which are not medically necessary as determined by the CG Provider Organization. Excluded services include, but are not limited to, weight reduction procedures designed to restrict your ability to assimilate food, gastric bypass, gastric balloons, jaw wiring, stomach stapling and jejunal bypass.
- for dressings, ostomy supplies, and other consumable supplies, unless received while a person is Confined in a Hospital or when used by a skilled home care professional.
- for procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion.
- routine refractions, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- for routine footcare, including paring and removing of corns and calluses or trimming of nails except when medically necessary.
- for membership costs or fees associated with health clubs or weight loss clinics.
- for non-medical ancillary services including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy for learning disabilities, developmental delays, autism or mental retardation.
- for medical or surgical services for treatment for control of obesity, except when a person has complied with more conservative treatments for control of morbid obesity.
- for injectible drugs.
- for transsexual surgery (including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery) and penile implants.
- for reversal of voluntary sterilization procedures.
- for therapy to improve general physical condition, including, but not limited to, cardiac rehabilitation and pulmonary rehabilitation programs, and any rehabilitation therapy except as provided for short-term therapy as described in The Schedule.
- therapy to improve general physical condition including, but not limited to, routine, long term or

non-medically necessary chiropractic care and rehabilitative services which are provided to reduce potential risk factors where significant therapeutic improvement is not expected.

- for fees associated with the collection of blood or blood products, except for autologous donation in anticipation of scheduled surgery where the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- for artificial aids including, but not limited to, crutches, splints, braces, corrective orthopedic shoes, arch supports, orthotics, elastic stockings, garter belts, corsets, hearing aids, eyeglass lenses and frames, contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post-cataract surgery), dentures and wigs.
- for treatment by acupuncture.
- for amniocentesis, ultrasound, or any other procedures requested solely for sex determination of a fetus, unless medically necessary to determine the existence of a sex-linked genetic disorder.
- for the cost of biologicals that are immunizations or medicines for the purpose of travel, or to protect against occupational hazards and risks.
- for cosmetic, dietary supplements, nutritional formulae, and health and beauty aids.
- which satisfy the Hospital or Skilled Nursing Facility Deductible shown in The Schedule for Hospital Benefits.
- for Durable Medical Equipment or External Prosthetic Appliances.
- for or in connection with Mental Illness or Substance Abuse.
- for which benefits are not payable according to the "General Limitations" section.

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GM6000 MM5-CHA MAJ154 CT

- for or in connection with an Injury or a Sickness which is a Pre-existing Condition, unless those expenses are incurred after a continuous, one-year period during which a person is satisfying a waiting period and/or is insured for these benefits.

Pre-Existing Condition

A Pre-existing Condition is an Injury or a Sickness for which a person receives treatment, incurs expenses or receives a diagnosis from a Physician during the 90 days before the earlier of the date that person: begins an eligibility waiting period, or becomes insured for these benefits.

Exceptions to Pre-existing Condition Limitation

Pregnancy and genetic information with no related treatment, will not be considered Pre-existing conditions.

A newborn child, an adopted child, or a child placed for adoption before age 18 will not be subject to any Pre-existing Condition Limitation. If such child was covered within 30 days of birth, adoption or placement for adoption. Such waiver will apply only if less than 63 days elapse between coverage during a prior period of Creditable Coverage and coverage under this plan.

Credit for Coverage under Prior Plan

If a person was previously covered under a plan which qualifies as Creditable Coverage, the following will apply, provided he notifies the Employer of such prior coverage, and fewer than 63 days elapse between coverage under the prior plan and coverage under this plan, exclusive of any waiting period.

CG will reduce any Pre-existing Condition limitation period under this policy by the number of days of prior Creditable Coverage you had under a creditable health plan or policy, up to 12 months for a timely enrollee and 18 months for a Late Entrant.

GM6000MM6 MAJ54V61

Certification of Prior Creditable Coverage

You must provide proof of your prior Creditable Coverage in order to reduce a Pre-existing Condition limitation period. You should submit proof of prior coverage with your enrollment material. Certification, or other proofs of coverage which need to be submitted outside the standard enrollment form process for any reason, may be sent directly to: Eligibility Services, CIGNA HealthCare, P.O. Box 9077, Melville, NY 11747-9077. You should contact the plan administrator or CIGNA Customer Service Representative if assistance is needed to obtain proof of prior Creditable Coverage. Once your prior coverage records are reviewed and credit is calculated, you will receive a notice of any remaining Pre-existing condition limitation period.

Creditable Coverage

Creditable Coverage will include coverage under: a self-insured employer group health plan; individual or group health insurance indemnity or HMO plans; state or federal continuation coverage; individual or group health conversion plans; Part A or Part B of Medicare; Medicaid, except coverage solely for pediatric vaccines; the Indian Health Service; the Peace Corps Act; a state health benefits risk pool; a public health plan; health coverage for current or former members of the armed forces and their Dependents; medical savings accounts; and health insurance for federal employees and their Dependents.

GM6000 MM6 MAJ54V62

Medical Conversion Privilege For You and Your Dependents

When a person's Medical Expense Insurance ceases, he may be eligible to be insured under an individual policy of medical care benefits (called the Converted Policy). A Converted Policy will be issued by CG only to a person who is Entitled to Convert, and only if he applies in writing and pays the first premium for the Converted Policy to CG within 31 days after the date his insurance ceases. Evidence of good health is not needed.

Employees Entitled To Convert

You are Entitled To Convert Medical Expense Insurance for yourself and all of your Dependents who were insured when your insurance ceased, except a Dependent who is eligible for Medicare or would be Overinsured, but only if:

- You have been insured for at least three consecutive months under the policy or under it and a prior policy issued to the Policyholder.
- Your insurance ceased because you were no longer in Active Service or no longer eligible for Medical Expense Insurance; or the policy cancelled.
- You are not eligible for Medicare.
- You would not be Overinsured.

If you retire you may apply for a Converted Policy within 31 days after your retirement date in place of any continuation of your insurance that may be available under this plan when you retire, if you are otherwise Entitled to Convert.

Dependents Entitled To Convert

The following Dependents are also Entitled to Convert:

- a child whose insurance under this plan ceases because he no longer qualifies as a Dependent or because of your death;
- a spouse whose insurance under this plan ceases due to divorce, annulment of marriage or your death;
- your Dependents, if you are not Entitled to Convert solely because you are eligible for Medicare;

but only if that Dependent: (a) was insured when your insurance ceased; (b) is not eligible for Medicare; and (c) would not be Overinsured.

GM6000 CP1 V-1
GM6000 CP2 CON2

Overinsured

A person will be considered Overinsured if either of the following occurs:

- His insurance under this plan is replaced by similar group coverage within 31 days.
- The benefits under the Converted Policy, combined with Similar Benefits, result in an excess of insurance based on CG's underwriting standards for individual policies. Similar Benefits are: (a) those for which the person is covered by another hospital, surgical or medical expense insurance policy, or a hospital, or medical service subscriber contract, or a medical practice or other prepayment plan or by any other plan or program; or (b) those for which the person is eligible, whether or not covered, under any plan of group coverage on an insured or uninsured basis; or (c) those available for the person by or through any state, provincial or federal law.

Converted Policy

The Converted Policy will be one of CG's current offerings at the time the first premium is received based on its rules for Converted Policies. It will comply with the laws of the jurisdiction where the group medical policy is issued. However, if the applicant for the Converted Policy resides elsewhere, the Converted Policy will be on a form which meets the conversion requirements of the jurisdiction where he resides. The Converted Policy offering may include medical benefits on a group basis. The Converted Policy need not provide major medical coverage unless it is required by the laws of the jurisdiction in which the Converted Policy is issued.

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GM6000 CP3 CON26

The Converted Policy will be issued to you if you are Entitled to Convert, insuring you and those Dependents for whom you may convert. If you are not Entitled to Convert and your spouse and children are, it will be issued to the spouse, covering all such Dependents. Otherwise, a Converted Policy will be issued to each Dependent who is Entitled to Convert. The Converted Policy will take effect on the day after the person's insurance under this plan ceases. The premium on its effective date will be based on: (a) class of risk and age; and (b) benefits.

The Converted Policy may not exclude any pre-existing condition not excluded by this plan. During the period of the Medical Benefits Extension of this plan, the amount payable under the Converted Policy will be reduced so that the total amount payable under the Converted Policy and the Medical Benefits Extension of this plan will not be more than the amount that would have been payable under this plan if the person's insurance had not ceased. After that, the amount payable under the Converted Policy will be reduced by any amount still payable under the Medical Benefits Extension of this plan.

CG or the Policyholder will give you, on request, further details of the Converted Policy.

GM6000 CP4 CON29 M

General Limitations - Medical Benefits

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Sickness or Injury;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay or for which you are not billed or for which you would not have been billed except that they were covered under this policy;
- for charges which would not have been made if the person had no insurance;
- to the extent that they are more than Reasonable and Customary Charges;
- for charges for unnecessary care, treatment or surgery, except as specified in any certification requirement shown in the PAC/CSR Requirements and Pre-Authorization section, of the Medical Care Benefits section;
- for or in connection with Custodial Services, education or training;
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;

GM6000 GL1-CHA GEN16V2 M
GM6000 GL2-CHA

- for charges made by an assistant surgeon in excess of 20 percent of the surgeon's allowable charge; or for charges made by a co-surgeon in excess of the surgeon's allowable charge plus 20 percent; (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.);
- for charges made for or in connection with the purchase or replacement of contact lenses; except, the purchase of the first pair of contact lenses that follows cataract surgery will be covered;
- for charges for supplies, care, treatment or surgery which are not considered essential for the necessary care and treatment of an Injury or Sickness, as determined by CG;

- for or in connection with speech therapy, if such therapy is: (a) used to improve speech skills that have not fully developed; (b) can be considered custodial or educational; or (c) is intended to maintain speech communication; speech therapy which is not restorative in nature will not be covered;
- for charges made by any covered provider who is a member of your family or your Dependent's family.

GM6000 GL2-CHA GEN246V1 M

- for Experimental, Investigational or Unproven Services which are medical, surgical, psychiatric, substance abuse or other healthcare diagnoses, treatments, procedures, drug therapies, technologies, supplies or devices that are determined by CG, in its sole discretion, to be:

  (a) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information or in medical literature. Medical literature means scientific studies published in a peer reviewed national professional journal; or

  (b) the subject of review or approval by an Institutional Review Board for the proposed use; or

  (c) the subject of an ongoing clinical trial that meets the definition of a phase I, II, or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight; or

  (d) not demonstrated, through existing peer-reviewed literature, to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

- for or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- for non-medical ancillary services, including but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety and services, training or educational therapy for learning disabilities, developmental delays, autism or mental retardation.

GM6000 GEN391 CHA

- to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:

  a. "no-fault" insurance law; or

  b. an uninsured motorist insurance law.

  CG will take into account any adjustment option chosen under such part by you or any one of your Dependents.

- for or in connection with an elective abortion unless:

  a. the Physician certifies in writing that the pregnancy would endanger the life of the mother; or

  b. the expenses are incurred to treat medical complications due to the abortion.

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GM6000 GL9-CHA GEN156

Medicare Eligibles

The Medical Expense Insurance for:

(a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(b) a former Employee's Dependent or a former Dependent Spouse who is eligible for Medicare and whose insurance is continued for any reason as provided in this plan;

(c) an Employee of an Employer who participates in a group health plan in which all Participating Employers have fewer than 100 Employees, if that Employee is eligible for Medicare due to disability;

(d) the Dependent of an Employee of an Employer who participates in a group

health plan in which all Participating Employers have fewer than 100 Employees, if that Dependent is eligible for Medicare due to disability;

(e) an Employee or a Dependent of an Employee of an Employer who has fewer than 20 Employees if that person is eligible for Medicare due to age;

(f) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

GM6000 ME2 MEL23V3

will be modified, where permitted by the rules established by the Social Security Act of 1965 as amended, as follows:

The amount payable under this plan will be reduced so that the total amount payable by Medicare and by CG will be no more than 100% of the expenses incurred.

CG will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (a) through (f) above.

GM6000 ME2 MEL45V1

Coordination of Benefits

If you or any one of your Dependents is covered under more than on Plan (not including the Plan of Basic Benefits), benefits payable from all such Plans will be coordinated.

Coordination of Benefits will be used to determine the benefits payable for a person for any Claim Determination Period if, for the Allowable Expenses incurred in that Period, the sum of;

(a) the benefits that would be payable from this Plan in the absence of coordination; and

(b) the benefits that would be payable from all other Plans without Coordination of Benefits provisions in those Plans;

would exceed such Allowable Expenses.

The benefits that would be payable from this Plan for Allowable Expenses incurred in any Claim Determination Period in the absence of Coordination of Benefits will be reduced to the extent required so that the sum of:

(a) those reduced benefits; and

(b) all the benefits payable for those Allowable Expenses from all other Plans;

will not exceed the total of such Allowable Expenses. Benefits payable from all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of this Plan are determined if: (a) the Benefit Determination Rules would require this Plan to determine its benefits before that Plan; and (b) the other Plan has a provision that coordinates its benefits with those of this Plan and would, based on its rules, determine its benefits after this Plan.

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CG reserves the right to release to or obtain from any other Insurance Company or other organization of

person any information which, in its opinion, it needs for the purpose of Coordination of Benefits.

When payments which should have been made under this Plan based on the terms of this section have been made under any other Plans, CG will have the right to pay to any organizations making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered to be benefits paid under this Plan. CG will be released from all liability under this Plan to the extent of these payments. When an overpayment has been made by CG at any time, it will have the right to recover that payment, to the extent of the excess, form the person to whom it was made or any other Insurance Company or organization, as it may determine.

Plan

Plan means any of the following which provides medical or dental benefits or services: (a) individual, group, blanket or franchise insurance coverage other than blanket group or franchise school accident policies; (b) service plan contracts, group or individual practice or other prepayment plans; or (c) coverage under any: labor-management trusteed plans; union welfare plans; employer organization plans; or employee benefit organization plans. Plan does not include coverage under hospital indemnity policies or contracts. Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Allowable Expense

Allowable Expense means any necessary, reasonable and customary item of expense, at least a part of which is covered by any one of the plans that covers the person for whom claim is made. When the benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid. Allowable Expense will not include the difference between: (a) the cost of a private room; and (b) the cost of a semiprivate room; except while the person's stay in a private room is medically necessary in terms of generally accepted medical practice.

Claim Determination Period

Claim Determination Period means a contract year or that part of a contract year in which the person has been covered under this plan.

Benefit Determination Rules

The rules below establish the order in which benefits will be determined:

(1) The benefits of a Plan which covers the person for whom claim is made other than as a dependent will be determined before a plan which covers that person as a dependent.

(2) The benefits of a Plan which covers the person for whom claim is made as a dependent of a person whose day of birth occurs first in a calendar year will be determined before a Plan which covers that person as a dependent of a person whose day of birth occurs later in that year; except that: (a) if the other Plan does not have this rule, its alternate rule will govern; and (b) in the case of a dependent child of divorced or separated parents, the rules in item (3) will apply.

(3) If there is a court decree which establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan which covers the child as a dependent of the parent so responsibility will be determined before any other plan; otherwise:

   (a) The benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before a Plan which covers the child as a dependent of a stepparent or a parent without custody.

   (b) The benefits of a Plan which covers the child as a dependent of a stepparent will be determined before a plan which covers the child as a dependent of the parent without custody.

(4) When the above rules do not establish the order, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time; except that:

   (a) The benefits of a Plan which covers the person as a laid-off or retired employee, or his dependent will be determined after a Plan which covers the person as an employee, other than a laid-off or retired employee, or his dependent.

   (b) If the other Plan does not have the rule in item (4)(a), which results in each Plan determining its

benefits after the other, then item (4)(a) will not apply.

GM6000 COB11 COR35

Expenses for Which a Third Party May Be Liable

This policy does not cover expenses for which another party may be responsible as a result of having caused or contributed to the Injury or Sickness. If you incur a Covered Expense for which, in the opinion of CG, another party may be liable:

1. CG shall, to the extent permitted by law, be subrogated to all rights, claims or interests which you may have against such party and shall automatically have a lien upon the proceeds of any recovery by you from such party to the extent of any benefits paid under the Policy. You or your representative shall execute such documents as may be required to secure CG's subrogation rights.
2. Alternatively, CG may, at its sole discretion, pay the benefits otherwise payable under the Policy. However, you must first agree in writing to refund to CG the lesser of:
   a. the amount actually paid for such Covered Expenses by CG; or
   b. the amount you actually receive from the third party for such Covered Expenses;

   at the time that the third party's liability is determined and satisfied, whether by settlement, judgment, arbitration or award or otherwise.

GM6000 CCP7 CCL7

Payment of Benefits

To Whom Payable

All Medical Benefits are payable to you. However, at the option of CG and with the consent of the Policyholder, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

If any person to whom benefits are payable is a minor or, in the opinion of CG, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

GM6000 POB12 PMT135V9

Termination of Insurance - Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.

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GM6000 TER 1 TRM23V3

Termination of Insurance - Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

GM6000 TER 4 TRM62

Termination of Insurance - Continuation Required by Federal Law for You and Your Dependents

The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income.

Federal law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

A. Employees and Dependents Continuation Provision

If you and your Dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you or your Dependent may continue health insurance upon payment of the required premium to the Employer. To continue Medical Insurance, you must elect continuation coverage under Basic Benefits. You and your Dependents must elect to continue insurance within 60 days from the later of: (a) the date of a reduction of your work hours or your termination of employment; or (b) the date notice of the right to continue insurance is sent. You must pay the first premium within 45 days from the date you elect to continue coverage. Such insurance will not be continued by CG for you and/or your Dependents, as applicable, beyond the earliest of the following dates:

- 18 months from the date your work hours are reduced or your employment terminates, whichever may occur first;
- the date the policy cancels;
- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date your Dependent ceases to qualify as an eligible Dependent;
- after you elect to continue this insurance, the date you become entitled to Medicare, and for your Dependent, the date he first becomes entitled to Medicare;
- after you elect to continue this insurance, for you, the date you first become covered under another group health plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.
- the date your continuation coverage under Basic Benefits ends.

B. Dependent Continuation Provision

If health insurance for your Dependents would otherwise cease because of:

(1) your death;

(2) divorce or legal separation; or

(3) with respect to a Dependent child, failure to continue to qualify as a Dependent,

such insurance may be continued upon payment of the required premium to the Employer. To continue Dependent Medical Insurance, you must elect continuation coverage under Basic Benefits for the Dependent. In the case of (2) or (3) above, you or your Dependent must notify your Employer within 60 days of such event. In addition, a Dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

CG will not continue the health insurance of a Dependent beyond the earliest of the following dates:

- 36 months from the date of (1), (2) or (3) above, whichever may occur first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- after the Dependent elects to continue this insurance, the date the Dependent first becomes entitled to Medicare, following his/her enrollment in Medicare;
- the date the policy cancels; or

- after the Dependent elects to continue this insurance, the date the Dependent first becomes covered under another group health plan, unless the Dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above;
- the date continuation coverage under Basic Benefits for the Dependent ends.

C. Subsequent Events Affecting Dependent Coverage

If, within the initial 18 month continuation period, your Dependent would lose coverage because of an event described in (1), (2), or (3) of Section B, or because of your coverage loss due to your subsequent entitlement to Medicare, after you have continued your Dependent's coverage due to your employment termination or reduction in work hours, your Dependent may continue coverage for up to 36 months from the date of loss of employment or reduction in work hours.

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If your employment ends or your work hours are reduced within 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

If your employment ends or your work hours are reduced more than 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 18 months from the date your employment ends or your work hours are reduced.

Disabled Individuals Continuation Provisions

If you or your Dependent is disabled before or within the first 60 days of continuation of coverage which follow termination of employment or a reduction in work hours, the disabled person may continue health insurance for up to an additional 11 months beyond the 18-month period.

If you or your Dependents who are not disabled elect to continue coverage, such family members of the disabled person may extend coverage for up to an additional 11 months, if they otherwise remain eligible, and notice of disability is provided as described in (b), below.

To be eligible you or your Dependent must:

a) be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and

b) notify the plan administrator of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the plan administrator with a copy of the determination.

Termination of coverage for all covered persons during the 29-month period will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning more than 30 days after the date of the final determination.

All reasons for termination described in sections A and B which apply to the initial 18 months will also apply to any or all covered persons for any additional months of coverage.

D. Effect of Employer Chapter 11 proceedings on Retiree Coverage

If you are covered as a retiree, and a proceeding under USC Chapter 11, bankruptcy for the Employer results in a substantial loss of coverage for you or your Dependents within one year before or after such proceedings, coverage will continue until: (a) for you, your death; and (b) for your Dependent surviving spouse or Dependent child, up to 36 months from your death.

GM6000 TER5 TRM140V40 TRM140V41

Conversion Available Following Continuation

If you or your Dependent's Continuation ends due to the expiration of the maximum 18-, 29- or 36-month continuation period, whichever applies, you or your Dependent may be entitled to convert to the insurance in accordance with the Medical Conversion benefit then available to Employees and their Dependents.

Interaction With Other Continuation Benefits

A person who is eligible to continue insurance under both (1) and (2) below may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of: (1) the continuation required by federal law; or (2) any other continuation of insurance provided in this Certificate.

Newly Acquired Dependents

If, while your insurance is being continued under the continuation required by federal law provisions, you acquire a new Dependent, such Dependent will be eligible for this Continuation provided:

- the required premium is paid; and
- CG is notified of your newly acquired Dependent in accordance with the terms of the policy.

If events (1) or (2) of Section B should subsequently occur for your newly acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

If events described in Section C should subsequently occur for your child who is born, adopted or placed for adoption as a newly acquired Dependent, coverage will be continued according to that section.

GM6000 TER5 TRM141V9

Termination of Insurance - Requirements of Family and Medical Leave Act of 1993

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

GM6000 TER5 TRM191V1

Medical Benefits Extension During Hospital Confinement

If the medical benefits under this plan cease for you or your Dependent, and you or your Dependent are Confined in a Hospital on that date, Medical Benefits will be paid for Covered Expenses incurred in connection with that Hospital Confinement. However, no benefits will be paid after the earliest of:

- the date you exceed the Maximum Benefit, if any, shown in The Schedule;
- The date you are covered for medical benefits under another group plan;
- The date you or your Dependent is no longer Hospital Confined;
- 3 months from the date your medical benefits cease.

The terms of this Medical Benefits Extension will not apply to a child born as a result of a pregnancy which exists when you or your Dependent's Medical Benefits cease.

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Accident and Health Provisions

Notice of Claim

Written notice of claim must be given to CG within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms

When CG receives the notice of claim, it will give to the claimant, or to the Policyholder for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after CG receives notice of claim, he will be considered

to meet the proof of loss requirements of the policy if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination

CG, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

Legal Actions

No action at law or in equity will be brought to recover on the policy until at least 60 days after proof of loss has been filed with CG. No action will be brought at all unless brought within 3 years after the time within which proof of loss is required.

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Definitions

Basic Benefits

The term Basic Benefits means the group coverage provided by CIGNA HealthCare under its Group Service Agreement with the Employer.

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

Custodial Services

The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness (including mental illness, alcohol or drug abuse). Custodial Services include, but shall not be limited to:

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self-administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

Contract Year

The term Contract Year is as defined for Basic Benefits under the Group Service Agreement.

Custodial Services

The term Custodial Services means any services which are not intended primarily to treat a specific Injury or Sickness (including mental illness, alcohol or drug abuse). Custodial Services include, but shall not be limited to:

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking; (b) grooming; (c) bathing; (d) dressing; (e) getting in or out of bed; (f) toileting; (g) eating; (h) preparing foods; or (i) taking medications that can usually be self-administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

Dependent

Dependents are any one of the following persons who are enrolled for Basic Benefits:

- your lawful spouse; and
- any unmarried child of yours who is
  - less than 19 years old and primarily supported by you;
  - 19 years but less than the limiting age for Basic Benefits, enrolled in school as a full-time student and primarily supported by you; and
  - 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 31 days after the date the child ceases to qualify

above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

A child includes a legally adopted child, including that child from the first day of placement in your home. It also includes a stepchild who lives with you.

Anyone who is eligible as an Employee will not be considered as a Dependent.

No one may be considered as a Dependent of more than one Employee

Durable Medical Equipment

The term Durable Medical Equipment means equipment which:

- can withstand repeated use;
- is primarily and customarily used to serve a medical purpose;
- is generally not useful to a person in the absence of Sickness or Injury; and
- is appropriate for use in the home.

Employee

The term Employee means a full-time employee of the Employer.

Eligible Charges

Eligible Charges means charges made for treatment which is medically necessary.

Employer

The term Employer means an employer participating in the fund which is established under the agreement of Trust for the purpose of providing insurance.

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

External Prosthetic Appliance

The term External Prosthetic Appliance means a device which is used as a replacement or substitute for a missing body part and is necessary for the alleviation or correction of illness, injury or congenital defect.

Free-standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it has equipment for emergency care;
- it has a blood supply;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

Home Health Aide

The term Home Health Aide means a person who: (a) provides care of a medical or therapeutic nature; and (b) reports to and is under the direct supervision of a Home Health Care Agency.

Home Health Care Agency

The term Home Health Care Agency means a Hospital or a non-profit or public home health care agency which:

- therapeutic service under the supervision of a Physician or primarily provides skilled nursing service and other a Registered Graduate Nurse;
- is run according to rules established by a group of professional persons;
- maintains clinical records on all patients;
- does not primarily provide custodial care or care and treatment of the mentally ill;

but only if, in those jurisdictions where licensure by statute exists, that Home Health Care Agency is licensed and run according to the laws that pertain to agencies which provide home health care.

Home Health Care Plan

The term Home Health Care Plan means a plan for care and treatment of a person in his home. To qualify, the plan must be established and approved in writing by a Physician who certifies that the person would require confinement in a Hospital or Skilled Nursing Facility if he did not have the care and treatment stated in the plan.

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals; or
- a Free-standing Surgical Facility.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- an outpatient in a Hospital because of: (a) chemotherapy treatment; (b) surgery; or (c) planned tests ordered by a Physician before inpatient admission to the same Hospital;
- receiving emergency care in a Hospital for an Injury, on his first visit as an outpatient within 48 hours after the Injury is received; or
- Partially Confined for treatment of mental illness, alcohol or drug abuse or other related illness. Two days of being Partially Confined will be equal to one day of being Confined in a Hospital.

The term Partially Confined means continually treated for at least 3 hours but not more than 12 hours in any 24-hour period.

Injury

The term Injury means an accidental bodily injury.

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medically Necessary/Medical Necessity

Health care services and supplies which are determined by CG to be: (a) medically required to meet the basic health needs of the insured; (b) consistent with the diagnosis of the condition; (c) consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; (d) required for purposes other than the comfort and convenience of the patient or their Physician; (e) rendered in the least intensive setting that is appropriate for the delivery of health care; and (f) of demonstrated medical value.

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Mental Illness

The term "mental illness" means any disorder, other than a disorder induced by alcohol or drug abuse, which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin. In determining benefits payable, charges made for the treatment of any physiological symptoms related to a mental illness will not be considered to be charges made for treatment of a mental illness.

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse

who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

Outpatient Surgical Facility

The term Outpatient Surgical Facility means a licensed institution which: (a) has a staff that includes Registered Graduate Nurses; (b) has a permanent place equipped for performing Surgical Procedures; and (c) gives continuous Physician services on an outpatient basis.

Participation Date

The term Participation Date means the later of:

- The Effective Date of the policy; or
- The date on which your Employer becomes a participant in the plan of insurance authorized by the agreement of Trust.

Pharmacy

The term Pharmacy means a licensed establishment where prescription drugs are dispensed by a pharmacist.

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Psychologist.

Reasonable and Customary Charge

A charge will be considered Reasonable and Customary if:

- it is the normal charge made by the provider for a similar service or supply; and
- it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by CG.

To determine if a charge is Reasonable and Customary, the nature and severity of the Injury or Sickness being treated will be considered.

Sickness - For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

DEF

Miscellaneous

Additional Programs

CG may, from time to time, offer or arrange for various entities to offer discounts, benefits or other consideration to Employees for the purpose of promoting their general health and well being. Contact CG for details of these programs.

GM6000 PRM1

CONNECTICUT GENERAL LIFE INSURANCE COMPANY a CIGNA COMPANY (called CG)

Certificate Rider

No. CR AZ CHA

Policyholder: FIRST SECURITY BANK OF UTAH AS TRUSTEE OF THE HEALTH ACCESS INSURANCE TRUST

Rider Eligibility: Each Employee who is located in Arizona

This certificate rider forms a part of the certificate issued to you by CG describing the benefits provided under the policy(ies) specified above.

The provisions set forth in this certificate rider comply with legislative requirements of the state of Arizona regarding group insurance plans covering insureds located in Arizona. These provisions supersede any provisions in your certificate to the contrary unless the provisions in your certificate result in greater benefits.

Notice: This Certificate of insurance may not provide all the benefits and protections provided by law in Arizona. Please read this Certificate carefully.

Pre-Existing Condition Limitation

The Pre-Existing Condition Limitation described in the certificate will not apply to any person who was covered under the Employer's prior plan if he becomes covered under this plan on the effective date of this plan

Susan L. Cooper

Corporate Secretary

GM6000 R7CEP CHA AZ

Policy Provisions

The following sub-Section is added to the Section entitled "Policy Provisions" in your certificate:

WHEN YOU HAVE A COMPLAINT OR AN APPEAL

For the purposes of this section, any reference to "you", "your" or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted; and "Physician reviewers" are licensed Physicians or licensed Dentists depending on the care, treatment or service under review.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems. The following describes the process by which Members may obtain information and submit concerns regarding service, benefits and coverage. For more information, see the Benefit Inquiry and Appeals Information Packet ("Appeal Packet"). Upon membership renewal or at any time thereafter, you may request an additional Appeal Packet by contacting Member Services at the toll-free number that appears on your Benefit Identification Card.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call our toll-free number and explain your concern to one of our Customer Service representatives. You can also express that concern in writing. Please call or write to us at the following:

> Customer Services Toll-Free Number or address that appears on your Benefit Identification card, explanation of benefits or claim form.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

CG has a two step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing within two years of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone. Call or write to us at the toll-free number or address on your Benefit Identification card, explanation of benefits or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

Within five business days after receiving your request for review, CG will mail you and your Primary Care Physician ("PCP") or treating Provider a notice indicating that your request was received, and a copy of the Appeal Packet (sent to PCP or treating Provider upon request). For level one appeals, we will respond in writing with a decision [within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination (decision). We will respond within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if your PCP or treating Physician certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services; or your appeal involves nonauthorization of an admission or continuing inpatient Hospital stay. When an appeal is expedited, we will respond orally and in writing with a decision within the lesser of one business day or 72 hours.

Level Two Appeal

If you are dissatisfied with our level one decision, you may request a second review. To start a level two appeal, follow the same process required for a level one appeal. Please send your review request relating to denial of a requested service that has not already been provided within 365 days of the last denial. Your review requests relating to payment of a service already provided should be sent within two years of the last denial. To help us make a decision on your appeal, you

or your provider should also send us any more information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness, the Committee will consult with at least one Physician or Dentist reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request within five business days after receiving your request and schedule a Committee review. For required preservice and concurrent care coverage determinations, the Committee review will be completed within 15 calendar days. For postservice claims, the Committee review and written notification of the Appeal Committee's decision will be completed within 30 calendar days. If more time or information is needed to make the preservice or concurrent care determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review.

You may request that the appeal process be expedited if, your Primary Care Physician or treating Physician certifies in writing and provides supporting documentation that the time frames under this process are likely to cause a significant negative change in your medical condition which cannot be managed without the requested services, or your appeal involves non authorization of an admission or continuing inpatient Hospital stay. When an appeal is expedited, we will respond orally with a decision within 72 hours, followed up in writing.

At any time during the appeal process CG has the option to send your appeal directly to External Independent Review without making a decision during the appeal process.

External Independent Review

1. Eligibility

Under Arizona law, a Member may seek an Expedited or Standard External Independent Review after seeking any available Expedited Review, Level 1 Appeal, and Level 2 Appeal. Your request for an Expedited or Standard External Independent Review should be submitted in writing.

2. Deadlines Applicable to the Standard External Independent Review Process

After receiving written notice from CG that your Level 2 Appeal has been denied, you have 30 calendar days to submit a written request to CG for External Independent Review. Your request ***shall*** include any material justification or documentation to support your request for the service or payment of a claim.

a. Medical Necessity Issues

These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO"), that is procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review. If your appeal for External Independent Review involves an issue of medical necessity:

(1) Within five business days of receipt of your request for External Independent Review, CG will:

- mail a written notice to you, your PCP or treating provider, and the Director of the Arizona Department of Insurance ("Director of Insurance") of your request for External Independent Review, and
- send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at earlier appeal levels.

(2) Within five days of receiving our information, the Insurance Director must

send all submitted information to an external independent review organization (the "IRO").

(3) Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

(4) Within five business days of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider. If the IRO decides that CG should provide the service or pay the claim, CG must then authorize the service or pay the claim. If the IRO agrees with CG's decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.

b. Coverage Issues

These are cases where we have denied coverage because we believe the requested service is not covered under your certificate of coverage. For contract coverage cases, the Arizona Insurance Department is the independent reviewer. If your appeal for External Independent Review involves an issue of service of benefits coverage or a denied claim:

(1) Within five business days of receipt of your request for External Independent Review, CG will:

- mail a written notice to you, your PCP or your treating provider, and the Director of Insurance of your request for External Independent Review, and
- send the Director of Insurance: your request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

(2) Within 15 business days of the Director's receipt of your request for External Independent Review from CG, the Director of Insurance will:

- determine whether the service or claim is covered, and
- mail the decision to CG. If the Director decides that we should provide the service or pay the claim, we must do so.

(3) If the Director of Insurance is unable to determine an issue of coverage, the Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have five business days after receiving the IRO's decision to send the decision to us, you and your treating provider.

(4) CG will provide any covered service or pay any covered claim determined to medically necessary by the independent reviewer(s) and provide any service or pay any claim determined to be covered by the Director of Insurance regardless of whether or not CG elects to seek judicial review of the decision made through the External Independent Review Process.

(5) If you disagree with the Insurance Director's final decision of a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If CG disagrees with the Insurance Director's final decision, CG may also request a hearing before the OAH. A hearing must be requested within 30 calendar days of receiving the Insurance Director's decision.

3. Deadlines Applicable to the External Independent Review Process

After receiving written notice from CG that your Expedited Level 2 Appeal has been denied, you have only five business days to submit a written request to CG for an Expedited External Independent Review. Your request ***shall*** include any material justification or documentation to support your request for the service or payment of a claim.

a. Medical Necessity Issues

If your appeal for Expedited External Independent Review involves an issue of medical necessity:

(1) Within one business day of receipt of your request for an Expedited External Independent Review, CG will:

- mail a written acknowledgement to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and
- forward to the Director your request for Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of CG's decision, the criteria used and the clinical reasons for the decision, relevant portions of CG's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.

(2) Within two business days after the Director receives the information outlined above, the Director will choose an independent review organization (IRO) and forward to the organization all of the information received by the Director.

(3) Within five business days of receiving a case for Expedited External Independent Review from the Director, the IRO will evaluate and analyze the case and based on all the information received, render a decision and send the decision to the Director. Within one business day after receiving a notice of the decision from the IRO, the Director will mail a notice of the decision to you, your PCP or treating provider, and CG.

b. Coverage Issues

If your appeal for Expedited External Independent Review involves a contract coverage issue:

(1) Within one business day of receipt of your request for an Expedited External Independent Review , CG will:

- mail a written acknowledgment to you, your PCP or treating provider, and the Director of your request for Expedited External Independent Review, and
- forward to the Director your request for an Expedited External Independent Review, the terms of the agreement in your contract, all medical records and supporting documentation used to render the adverse decision, a summary description of the applicable issues including a statement of CG's decision, the criteria used and the clinical reasons for the decision, relevant portions of CG's utilization review plan and the name and the credentials of the licensed health care provider who reviewed the case.

(2) Within two business days after receipt of all the information outlined above, the Director will determine if the service or claim is covered and mail a notice of the determination to you, your PCP or treating provider, and CG.

(3) If the Director of Insurance is unable to determine an issue of coverage, the Director will forward your case to the IRO. The IRO will have five business days to make a decision and send it to the Director. The Director will have one business day after receiving the IRO's decision to send the decision to CG, you and your treating provider.

(4) CG will provide any covered service or pay any covered claim determined to be medically necessary by the independent reviewer(s) and provide any service or pay any claim determined to be covered by the Director regardless of whether CG elects to seek judicial review of the decision made through the External Independent Review Process.

(5) If you disagree with the Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If CG disagrees with the Director's final decision, CG may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision.

The Independent Review Program is a voluntary program arranged by CG.

Under Arizona law, if you intend to file suit regarding a denial of benefit claim or services you believe are medically necessary, you are required to provide written notice to CG at least 30 days before filing the suit stating your intention to file suit and the basis of your suit. You must include in your notice the following:

Member Name
Member Identification Number
Member Date of Birth
Basis of Suit (reasons, facts, date(s) of treatment or request)

Notice will be considered provided by you on the date received by CG. The notice of intent to file suit must be sent to CG via Certified Mail Return Receipt Request to the following address:

Attention: Appeals Supervisor
Notice of Intent to File Suit
CIGNA HealthCare of Arizona
1101 N. Black Canyon Highway
Phoenix, AZ 85029

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written documents required to be mailed during the process is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

Complaints to the Arizona Department of Insurance

The Director of the Arizona Department of Insurance is required by law to require any Member who files a complaint with the Arizona Department of Insurance relating to an adverse decision to first pursue the review process established by the Arizona Legislature and CG as described above.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitle to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. Your or your plan may have other voluntary alternative dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record or other information which (a) was relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document,record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against CG until you have completed the Level One and Level Two Appeal processes. If your Appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

CIGNA HealthCare 24-Hour Health Information Line℠ 1.800.564.8982

The Health Information Nurses

A specially trained team of registered nurses is on duty around the clock. Your nurse will ask you a few questions about your symptoms and situation, then direct you to the type of care that should make you more comfortable.

- If your condition doesn't require immediate care, your nurse will recommend steps you can take to be more comfortable until you see your doctor.
- If you're away from home, the nurses can help you locate nearby participating doctors, facilities and pharmacies.
- If you need urgent care, your nurse will direct you to the nearest qualified provider or facility and help you with any necessary authorizations.
- If it appears that you need emergency care, your nurse will direct you to call 911 or other emergency services in your area. Your nurse will help you access the appropriate services.
- If you're directed to seek immediate medical attention, we'll provide your primary care physician with the details. This information becomes part of your medical records, updates your health status and alert your doctor to the need for follow-up care.

The Health Information Library

You can listen to tapes on topics ranging from aging and women's health to nutrition and surgery. The tapes are regularly updated to include new treatments and medical data. You can listen to as many tapes as you like, and this booklet includes a handy directory to hundreds of subjects.

It's simple to use, easy to understand

- Just call 1.800.564.8982.
- Follow the simple instructions that quickly guide you to the information you need. If you have a rotary-dial phone, stay on the line for assistance.
- Use this handy directory to enter the code numbers of the programs you'd like to hear.
- There's no limit to the number of programs you can request in a single call.

Nurses are always standing by

To speak with a Health Information Nurse at any time during your call - even if you're in the middle of a Health Information Library tape - our system will quickly and automatically connect you.

Call us if you're concerned or just curious

- Use the 24-Hour Health Information Line for helpful, everyday health information on all sorts of subjects, from sleeplessness to sunburn.
- You'll really appreciate this service if you have young children.
- If it's difficult for your primary care physician to call you back - if you're vacationing or traveling on business, if you're retired and travel often, or if you have kids away at school - the Health Information Line is a valuable first step in learning about and caring for everyday health matters.

Don't wait, don't wonder, or possibly delay necessary treatment or helpful self-care. Call the CIGNA HealthCare 24-Hour Health Information Line℠ and get the information you need. Quickly and easily.

Health Information Library
1.800.564.8982

Aging

3000 A Healthy Life Style for Older Adults
3001 Abuse of Older Adults
3002 Adult Day Care Programs
3003 Advance Directives
3004 Alcohol and Aging
3005 Alzheimer's Disease
3006 Caregiver's Guide
3007 Constipation
3008 Dementia
3009 Dental Care for Older Adults
3010 Depression in Older Adults
3011 Elderhostel and Adult Education
3012 Erectile Dysfunction (Impotence)
3013 Exercise for Older Adults
3014 Fluid Requirements of Older Adult
3015 Health Benefits for Veterans
3016 Health Changes With Aging
3017 Home Healthcare
3018 Housing Options for Seniors
3019 How to Choose a Nursing Home
3020 Hypothermia in Older Adults
3021 Insomnia in Older Adults
3022 Loneliness in Older Adults
3023 Long-Term Care Insurance
3024 Medicaid
3025 Medicare: Health Insurance
3026 Medicines: Problems They Can Cause
3027 Nutrition for the Later Years
3028 Pets Benefit the Older Adult
3029 Retirement Planning
3030 Preventing a Broken Hip
3031 Medicines: Using Them Safely
3032 Self-Esteem in Older Adults
3033 Senior Centers
3034 Sexuality in the Later Years
3035 Skin Care and Protection
3036 Social Security and SSI
3037 Stress in Later Years
3038 Stroke
3039 Talking With Your Healthcare Provider

Allergies

3100 Allergies
3101 Allergies: National Support Services
3102 Allergy Proof Your Home
3103 Allergy Testing
3104 Allergy Treatment
3106 Contact Dermatitis
3107 Drug Allergy
3108 Eczema
3109 Food Allergy
3110 Hay Fever (Seasonal Allergic Rhinitis)
3111 Hives
3105 Insect Bites and Stings
3112 Poison Ivy, Sumac, and Oak
3113 Severe Allergic Reaction

Behavioral Health

3300 Abuse and Neglect--Children
3301 Abuse and Violence - Adults
3302 Aggressive Behavior in Children
3303 Agoraphobia
3304 Alcohol Dependence (Alcoholism)
3305 Alcoholism: Information and Resources
3306 Amnesia
3307 Anger Management
3308 Anorexia Nervosa
3309 Antisocial Personality Disorder
3311 Attention-Deficit/Hyperactivity Disorder (ADHD) in Adults
3312 Attention-Deficit/Hyperactivity Disorder (ADHD)
3313 Binge Eating Disorder (Compulsive Overeating)
3314 Bipolar Disorder (Manic-Depressive Illness)
3315 Bulimia Nervosa
3316 Club Drugs
3317 Cocaine Use
3318 Compulsive Gambling
3319 Confusion
3320 Delirium
3321 Depression
3322 Drug Abuse Among Teenagers
3323 Drug Abuse and Addiction
3324 Drug Abuse Resources
3325 Drugs in the Workplace
3326 Emotional Abuse - Effects on Children
3327 Exhibitionism
3328 Fetishism
3329 Gender Identity Disorder
3330 Grief and Loss
3331 Hallucinations
3332 Hazards of Smoking
3333 Hypnosis
3334 Hypochondria (Hypochondriasis Disorder)
3335 Incest
3336 Kleptomania
3337 Letting Go of Resentment
3338 Lying: Pathologic
3339 Masochism
3340 Mental Health Professionals
3341 Multiple Personality (Dissociative Identity Disorder)
3342 Narcissism (Narcissistic Personality Disorder)
3343 Nervous Breakdown
3344 Nightmares and Sleep Terrors
3345 Obsessive-Compulsive Disorder (OCD)
3346 Panic Attacks (Panic Disorder)
3347 Paranoid Personality Disorder
3348 Pedophilia
3349 Phobias
3350 Post-Traumatic Stress Disorder
3351 Prescription Drug Abuse
3352 Psychosis
3353 Psychosomatic Illness (Somatization Disorder)
3354 Pyromania
3355 Sadism
3356 Schizophrenia
3357 Seasonal Affective Disorder (SAD)
3358 Self-Esteem
3359 Sex Therapy
3360 Sexual Abuse and Children
3361 Smokeless Tobacco
3362 Smoking: Ways to Quit
3363 Suicide
3364 Teenage Drinking
3365 Transvestism
3366 Twelve Step Programs
3367 Types of Therapy for Mental Health
3368 Voyeurism

Bones, Joints and Muscles

3150 Achilles Tendon Injury
3151 Amputation
3152 Ankle Sprain
3153 Anterior Cruciate Ligament (ACL) Injury
3154 Arthritis
3155 Arthritis: Chores Made Easier
3156 Arthroscopic Meniscectomy
3157 Arthroscopy
3158 Artificial Limb
3159 Aspirin and Arthritis
3160 Athlete's Foot
3161 Back Pain Prevention: Body Mechanics
3162 Bone Infection (Osteomyelitis)
3163 Bowlegs and Knock-Knees
3164 Broken Ankle
3165 Broken Elbow
3166 Broken Finger
3167 Broken Wrist
3168 Bunion
3169 Bursitis
3170 Calcific Tendonitis
3171 Carpal Tunnel Syndrome
3172 Cast Care
3174 Corns and Calluses
3173 Costochondritis
3175 Dislocated Ankle
3176 Dislocated Elbow
3256 Dupuytren's Contracture
3177 Fibromyalgia
3178 Finger Dislocation
3179 Finger Sprain
3181 Flat Feet
3182 Foot Care
3183 Foot Injuries
3184 Foot Problems
3185 Fracture Treatment
3186 Fracture Types
3187 Frozen Shoulder
3188 Ganglion Cyst
3189 Gout
3190 Hammertoes
3191 Heel Pain
3192 Hip Dislocation in Childhood
3193 Hip Fracture
3194 Hip Injuries
3195 Hip Replacement Surgery
3196 Ingrown Toenail

3197 Jumper's Knee (Patellar Tendonitis)
3198 Juvenile Rheumatoid Arthritis
3199 Knee Arthroscopy
3200 Knee Cartilage Tear (Meniscal Tear)
3201 Knee Replacement Surgery
3202 Knee Sprain
3203 Legg-Calve-Perthes Disease
3204 Low Back Exercises
3205 Low Back Pain
3206 Lumbar Stenosis
3207 Lupus
3208 Mallet Finger (Baseball Finger)
3209 Muscle Cramps and Spasms
3210 Muscle Strain
3311 Neck Exercises
3312 Neck Injuries
3313 Neck Spasms
3314 Neck Strain
3315 Orthopedic Appliances
3216 Osgood-Schlatter Disease
3217 Osteoarthritis
3218 Osteogenesis Imperfecta
3219 Osteoporosis
3220 Over-Pronation
3221 Paget's Disease of Bone
3222 Physical Therapy
3223 Pigeon Toe (In-Toeing)
3224 Plantar Fasciitis
3225 Polymyalgia Rheumatica
3226 Polymyositis and Dermatomyositis
3227 Pulled Elbow in Children
3228 Rheumatoid Arthritis
3229 Rotator Cuff Injury
3230 Runner's Knee (Patellofemoral Pain Syndrome)
3231 Scleroderma
3232 Scoliosis
3233 Septic Arthritis
3234 Setting a Broken Bone (Without Surgery)
3180 Shoes: Proper Fit Prevents Problems
3235 Shoulder Bursitis
3236 Shoulder Dislocation
3237 Shoulder Injuries
3238 Shoulder Replacement Surgery
3239 Shoulder Separation
3240 Slipped Capital Femoral Epiphysis
3241 Slipped Disk (Herniated Disk)
3242 Spinal Fusion
3243 Spinal Instrumentation Surgery
3244 Spondylolysis and Spondylolisthesis
3245 Sprains
3246 Stress Fractures
3247 Surgery to Set a Broken Bone
3248 Tennis Elbow (Lateral Epicondylitis)
3249 Thumb Sprain
3250 Torticollis
3251 Trigger Finger
3252 Ultrasound Treatment
3253 Using Crutches Safely
3254 Whiplash
3255 Wrist Sprain

Brain and Nervous System

3400 Aids and the Nervous System
3401 Alzheimer's Disease
3402 Bacterial Meningitis in Adults
3403 Bell's Palsy
3404 Caring for Someone with Alzheimer's Disease
3405 Cluster Headaches
3406 Concussion
3407 Confusion
3408 Delirium
3409 Dementia
3410 Epilepsy
3411 Facial Tics
3412 Guillain-Barre Syndrome
3413 Head Trauma
3414 Huntington's Disease
3415 Hydrocephalus
3416 Lou Gehrig's Disease (ALS)
3417 Lumbar Puncture
3418 Migraine Headache
3435 Multiple Sclerosis (MS)
3419 Myasthenia Gravis
3420 Myelography
3421 Narcolepsy
3422 Neuralgias (Neuropathic Pain)
3423 Parkinson's Disease
3424 Peripheral Neuropathy
3425 Sciatica
3426 Seizures
3427 Sinus Headache
3428 Slipped Disk (Herniated Disk)
3429 Spinal Cord Injury
3430 Stroke
3431 Supportive Care for Progressive Dementia
3432 Tension Headache
3433 Trigeminal Neuralgia
3434 Viral Meningitis in Adults

Cancer

3500 Acute Leukemia
3501 Bladder Cancer
3502 Bone Cancer
3503 Bone Marrow Transplant / Stem Cell Transplant
3504 Brain Tumor
3505 Brain Tumors in Children
3506 Breast Cancer
3507 Breast Cancer in Men
3508 Cancer and Pain Control
3509 Cancer Information Resources
3510 Cancer Prevention and Diet
3511 Cancer Screening
3512 Cancer Surgical Treatment
3513 Cancer Treatment Team
3514 Cancer Treatment: Side Effects
3515 Cancer: Clinical Trials
3516 Cancer: Importance of Early Detection
3517 Cancer's Seven Warning Signs
3518 Cervical Cancer
3519 Chemotherapy
3520 Chronic Leukemia
3521 Colon Cancer
3522 Diagnosing Cancer
3523 Esophagus Cancer
3524 Hodgkin's Disease (Hodgkin's Lymphoma)
3525 Immunotherapy / Biotherapy
3526 Kidney Cancer
3527 Liver Cancer
3528 Lung Cancer
3529 Malignant Melanoma
3530 Metastatic Cancer
3531 Multiple Myeloma
3532 Non-Hodgkin's Lymphoma
3533 Ovarian Cancer
3534 Palliative Surgery
3535 Pancreatic Cancer
3536 Patient Controlled Analgesia System
3537 Prostate Cancer
3538 Prostate Specific Antigen (PSA)
3539 Protecting Yourself from Cancer
3540 Radiation Therapy
3541 Skin Cancer
3542 Smoking and Cancer
3543 Stomach Cancer
3544 Testicular Cancer
3545 Throat Cancer
3546 Thyroid Cancer
3547 Uterine Cancer
3548 Uterine Sarcoma

Cardiovascular Health

3600 Aneurysm
3601 Angina
3602 Angioplasty
3603 Aortic Valve Regurgitation
3604 Aortic Valve Stenosis
3605 Atherosclerosis
3606 Atrial Fibrillation
3607 Blood Clots
3608 Blood Pressure
3609 Cardiac Arrest
3610 Cardiac Rehabilitation
3611 Cardiomyopathy
3612 Chest Pain (Noncardiac)
3613 Children and Heart Disease
3614 Congenital Heart Disease
3615 Controlling Cholesterol
3616 Coronary Angiogram
3617 Coronary Artery Bypass Surgery
3618 Coronary Artery Disease
3619 Coronary Artery Disease: Managing Risk Factors
3620 Coronary Intensive Care Unit
3621 Deep Vein Thrombosis
3622 Diet and Heart Disease
3623 Exercise Test
3624 Heart Attack: Early Warning Signs
3625 Heart Catheterization
3626 Heart Disease: Prevention
3627 Heart Failure
3628 Heart Murmur
3629 Heart Palpitations
3630 Heart Transplant
3631 High Blood Pressure
3632 High Cholesterol (Hypercholesterolemia)
3633 Implantable Cardioverter Defibrillator (ICD)
3634 Infectious Endocarditis
3635 Low Blood Pressure
3636 Low Sodium Diet
3637 Mitral Valve Prolapse
3638 Mitral Valve Regurgitation
3639 Mitral Valve Stenosis
3640 Myocardial Infarction (Heart Attack)
3641 Myocarditis
3642 Pacemakers
3643 Paroxysmal Supraventricular Tachycardia (PSVT)
3644 Pericarditis
3645 Peripheral Vascular Disease
3646 Stroke
3647 Stroke Rehabilitation
3648 Superficial Thrombophlebitis
3649 Triglycerides
3650 Varicose Veins
3651 Ventricular Tachycardia

Child And Teen Health

3700 Alcoholic Parent
3701 Asthma in Children
3702 Attention-Deficit/Hyperactivity Disorder (ADHD)
3703 Attitude - Make It Positive!
3704 Autism
3705 Bacterial Meningitis in Children
3706 Bedwetting (Enuresis)
3707 Breast-Feeding
3708 Breast-Feeding: Advantages over Formula Feeding
3709 Burns in Children
3710 Chickenpox
3711 Childhood Cancers
3712 Circumcision
3713 Common Viral Infections
3714 Croup
3715 Crying Baby
3716 Dating Concerns
3717 Dental Care for Children
3718 Diaper Rash
3719 Divorce: a Teen's Point of View
3720 Dyslexia
3721 Earache in Children
3722 Fathering an Infant
3723 Feet: What Is Normal for Children?
3724 Fetal Alcohol Syndrome
3725 Formula Feeding
3726 Head Lice
3727 Hearing Loss in Children
3728 Hernias
3729 HIV / AIDs: Concerns for Young Adults
3730 Homosexuality and Teens
3731 Jaundice
3732 Kid Fitness
3733 Masturbation
3734 Measles
3735 Medicines Can Be Poisonous
3736 Mothering an Infant
3737 Mumps
3738 Muscular Dystrophy
3739 New Baby Creates Jealousy
3740 Newborn Screening Tests
3741 Nightmares and Night Terrors in Children
3742 Normal Development: 12 to 15 Months Old
3743 Normal Development: 15 to 18 Months Old
3744 Normal Development: 18 to 24 Months Old
3745 Normal Development: 2 to 4 Months Old
3746 Normal Development: 2 Weeks to 2 Months Old
3747 Normal Development: 2 Years Old
3748 Normal Development: 3 Years Old
3749 Normal Development: 4 to 6 Months Old
3750 Normal Development: 4 Years Old
3751 Normal Development: 5 Years Old
3752 Normal Development: 6 to 9 Months Old
3753 Normal Development: 9 to 12 Months Old
3754 Nutrition for Children
3755 Pregnancy Prevention for Young Men and Women
3756 Prevention of Sexually Transmitted Diseases
3757 Puberty for Boys
3758 Puberty for Girls
3759 Rashes
3760 Reye's Syndrome
3761 Rheumatic Fever in Children
3762 Rules: How to Live with Them
3763 Self Esteem
3764 Sleep Patterns in Children
3765 Sleep Patterns in Newborns
3766 Sleeplessness
3767 Speech and Language Problems
3768 Speech Development in 2 to 5 Year Olds
3769 Speech Development in Newborns to 2 Year Olds
3770 Spitting Up
3771 Sudden Infant Death Syndrome
3772 Teen Depression
3773 Teenage Love
3774 Teething
3775 Temper Tantrums
3776 Terrible Twos
3777 Thumbsucking
3778 Tic Disorders
3779 Toddler Discipline
3780 Toilet Training
3781 Tourette's Syndrome
3782 Type 1 Diabetes in Children
3783 Undescended Testicle
3784 Very Small Premature Baby
3785 Viral Meningitis in Children
3786 Weight Problems
3787 Whooping Cough (Pertussis)

Dental Health

3850 Bad Breath (Halitosis)
3851 Choosing a Dentist
3852 Dental Care for Children
3853 Dental Care for Infants
3854 Denture Care
3855 Gingivitis
3856 How to Take Care of Your Teeth
3857 Periodontal Disease
3858 Thrush
3859 Toothache

Diabetes and Other Hormonal Disorders

3900 Diabetes and Illness
3901 Diabetes: Foot Care
3902 Diabetes: Food Management
3903 Diabetes: Self Blood Glucose Monitoring
3904 Diabetes: the Importance of Exercise
3905 Diabetes: Type 1
3906 Diabetes: Type 2
3907 Diabetic Eye Problems
3908 Diabetic Ketoacidosis
3909 Diabetic Retinopathy
3910 Endocrine Disorders
3911 Growth Delay Causes
3912 High Blood Sugar (Hyperglycemia)
3913 Hyperosmolar Hyperglycemic Nonketotic Syndrome
3914 Hyperthyroidism
3915 Hypoglycemia
3916 Hypothyroidism
3917 Metabolic Syndrome
3918 Pituitary Disorders
3919 Precocious Puberty in Boys
3920 Precocious Puberty in Girls

Digestive System

4000 Acute Pancreatitis
4001 Anal Fissure
4002 Anal Fistula
4003 Appendicitis
4004 Cholecystostomy
4005 Chronic Pancreatitis
4006 Cirrhosis
4007 Colon and Rectal Polyps
4008 Constipation
4009 Crohn's Disease
4010 Diarrhea
4011 Diverticulitis
4012 Diverticulosis
4013 Duodenal Ulcer
4014 Gallbladder Disease / Gallstones
4015 Gallbladder Removal (Cholecystectomy)
4016 Gastric Ulcer
4017 Gastritis
4018 Gastrostomy Feeding Tube Placement
4019 Groin (Inguinal) Hernia
4020 Groin (Inguinal) Hernia Repair
4021 Heartburn
4022 Hemorrhoidectomy
4023 Hemorrhoids
4024 Hepatitis A
4025 Hepatitis B
4026 Hepatitis C
4027 Hiatal Hernia
4028 Ileostomy and Colostomy
4029 Indigestion
4030 Intestinal Gas (Flatulence)
4031 Irritable Bowel Syndrome (Spastic Colon)
4032 Laparoscopic Cholecystectomy
4033 Laxative Abuse
4034 Pilonidal Disease
4035 Rectal Bleeding
4036 Rectal Itching
4037 Stomach Flu (Viral Gastroenteritis)
4038 Traveler's Diarrhea
4039 Ulcerative Colitis
4040 Viral Hepatitis

Ear, Nose and Throat

3950 Ear Infection: Middle Ear (Otitis Media)
3951 Ear Infection: Outer Ear (Otitis Externa)
3952 Ear Infections
3953 Earwax
3954 Hearing Loss in Adults
3955 Laryngitis
3956 Nosebleed (Epistaxis)
3957 Ruptured Eardrum
3958 Sinusitis
3959 Sore Throat
3960 Strep Throat
3961 Tonsillectomy and Adenoidectomy (T & A)

Exercise and Fitness

4100 Achilles Tendon Injury
4101 Aerobic Dance Injuries
4102 Altitude Sickness
4103 Anabolic Steroids
4104 Ankle Sprain
4105 Athletic Amenorrhea
4106 Athletic Shoes: the Right Ones

4107 Caffeine and Athletic Performance
4108 Circuit Strength Training
4109 Cross Training
4110 Cross-Country Skiing
4111 Cycling Injuries
4112 Personal Fitness Plan
4113 Diathermy / Deep Tissue Heat Treatment
4114 Dynamic Vs Static Exercise
4115 Eating Before Exercise
4116 Electrical Nerve Stimulation
4117 Exercise and Weight Control
4118 Exercise to Stay Healthy
4119 Female Athletes
4120 Finger Sprain
4121 Flexibility and Its Importance
4122 Fluid Replacement
4123 Groin Strain
4124 Growth Hormone Supplements
4125 Hamstring Strain
4126 Home Exercise Equipment
4127 Ice Therapy
4128 Athletic Performance Using Ergogenic Aids
4129 Kid Fitness
4130 Knee Injuries
4131 Mallet Finger (Baseball Finger)
4132 Measuring Body Fat
4133 Morton's Neuroma
4134 Muscle Cramps and Spasms
4135 Neck Injuries
4136 Neck Stinger
4137 Orthopedic Examination Before Exercise
4138 Orthotics
4139 Overuse Injuries
4140 Physical Examination Before Exercise
4141 Preventing Sports Injuries
4142 Rice: Rest, Ice, Compression, Elevation
4143 Rowing
4144 Runner's Knee (Patellofemoral Pain Syndrome)
4145 Running Injuries
4146 Running or Jogging
4147 Running Shoes: Finding the Right Fit
4148 Shin Pain (Shin Splints)
4149 Shoulder Injuries
4150 Sports Drinks
4151 Stairclimbing Machines
4152 Step Training
4153 Strength Training
4154 Stretching
4155 Swimming and Water Exercise
4156 Exercise: Effects of Temperature and Humidity
4157 Tendonitis
4158 Tennis Elbow (Lateral Epicondylitis)
4159 Training Heart Rates
4160 Vitamin and Mineral Supplements for Athletes
4161 Walking
4162 Walking Injuries
4163 Wrist Sprain

Eyes and Vision

4200 Cataract
4201 Cataract Extraction Surgery
4202 Color Blindness
4203 Common Vision Problems
4204 Contact Lens Care: Gas Permeable Lenses
4205 Contact Lens Care: Soft Contact Lenses
4206 Corneal Abrasions
4207 Crossed or Misaligned Eyes (Strabismus)
4208 Double Vision
4209 Eye Allergy (Allergic Conjunctivitis)
4210 Eye Care
4211 Eye Exam
4212 Eye Symptoms Demanding Immediate Attention
4213 Eyelid Cyst (Chalazion)
4214 Eyestrain
4215 Flashes and Floaters
4216 Glaucoma
4217 Lazy Eye (Amblyopia)
4218 Pinkeye (Viral or Bacterial Conjunctivitis)
4219 Retinal Detachment
4220 Something in Your Eyes
4221 Stye
4222 Sunglasses
4223 Types of Contact Lenses

Family Health

4300 Adoption
4301 Anger Management for Parents
4302 Birth Control
4303 Birth Control Patch
4304 Birth Control Pills
4305 Cerebral Palsy
4306 Cervical Cap
4307 Child Spacing
4308 Children's Insecurities
4309 Communicating with Your Teen
4310 Cystic Fibrosis
4311 Depo-Provera
4312 Diaphragm
4313 Discipline and Punishment
4314 Down Syndrome
4315 Emergency Birth Control (Morning-After Pill)
4316 Family Communication
4317 Female Condom
4318 Female Sterilization
4319 Fertility Drugs
4320 Finding and Choosing Child Care
4321 Hemophilia
4322 In Vitro Fertilization
4323 Infertility
4324 Intrauterine Device (IUD)
4325 Male Condom
4326 Natural Family Planning
4327 Norplant
4328 Parenting Roles
4329 Preventing Separation Anxiety
4330 Reverse Tubal Ligation
4331 Reverse Vasectomy
4332 Sexual Abstinence
4333 Sibling Relationships
4334 Sickle Cell Anemia
4335 Single Parenting
4336 Spermicides
4337 Spina Bifida
4338 Talking with Your Child About Drinking and Drugs
4339 Talking with Your Child About HIV
4340 Talking with Your Kids About Sex
4341 Teenage Pregnancy
4342 Vaginal Contraceptive Ring
4343 Vasectomy
4344 Your Child's Self-Esteem

General Health

4400 Alcohol and Health
4401 Altitude Sickness
4402 Anemia
4403 Blood Donation Procedure
4404 Blood Transfusions
4405 Choosing a Primary Care Provider
4406 Chronic Fatigue Syndrome
4407 Communication in Intimate Relationships
4408 Dealing with Disfigurement
4409 Detecting a Hearing Loss
4410 Excessive Hair Growth (Hirsutism)
4411 Exercise Reduces Stress
4412 Fever Management
4413 Financial Concerns
4414 Hearing Aids
4415 Hearing Impaired: Assistive Devices
4416 Hiccups
4417 Home Healthcare
4418 Hospice
4419 Occupational Therapy
4420 Physical Therapy
4421 Restless Legs Syndrome
4422 School Disruptions and Chronic Illness
4423 Secondhand Smoke
4424 Speech Therapy
4425 Stress
4426 Stress Management
4427 Stress Management: Deep Breathing
4428 Stress Management: Mental Imaging
4429 Stress Management: Progressive Muscle Relaxation
4430 Talking with Your Healthcare Provider
4431 Telephone Assistive Devices
4432 Temporomandibular Joint Syndrome (TMJ)
4433 The Stresses of Chronic Illness
4434 Touching in Renewing Sexuality
4436 Vital Signs: Temperature, Pulse, Respiration, and BP
4437 Water: Essential for Good Health

Infectious Diseases

4500 AIDs: Risk Factors and Prevention of Transmission
4501 Canker Sores
4502 Cellulitis
4503 Chlamydial Infection in Men
4504 Chlamydial Infection in Women
4505 Cold Sores (Fever Blisters)
4506 Common Cold
4507 Dengue Fever
4508 Fifth Disease
4509 Food Poisoning: Salmonellosis
4510 Genital Herpes
4511 Genital Warts
4512 Gonorrhea
4513 Group A Streptococcus
4514 Hand-Foot-And-Mouth Disease
4516 HIV Infection and AIDs
4517 HIV Infection from Blood Transfusions
4518 HIV/AIDs: Workplace Issues
4519 HIV-1 Antibody Test (Elisa and Western Blot)
4520 Human Papillomavirus (HPV)

4521 Infectious Mononucleosis
4522 Influenza
4523 Legionnaires' Disease
4524 Lice
4525 Lyme Disease
4526 Pinworms
4527 Rheumatic Fever
4528 Ringworm
4529 Roseola
4530 Rubella
4531 Scabies
4532 Severe Acute Respiratory Syndrome (SARS)
4533 Sexually Transmitted Disease Prevention
4534 Shingles (Herpes Zoster)
4535 Skin Infection
4536 Skin or Soft Tissue Abscess
4537 Syphilis
4538 Tetanus
4539 Trichomoniasis
4540 Tuberculosis (TB)
4541 Viral Hepatitis
4542 West Nile Virus

Medications

4250 Ace Inhibitors
4251 Antacids
4252 Antibiotics
4253 Antidepressant Medicines
4254 Antidiarrheal Medicines
4255 Anti-Inflammatory Medicines
4256 Ask About Your Medicines
4257 Beta Blockers
4258 Calcium Channel Blockers
4259 Corticosteroids
4260 Cough Medicine
4261 Decongestants Versus Antihistamines
4262 Diuretics
4263 Drug Interactions
4264 Generic and Brand-Name Drugs
4265 Growth Hormone Supplements
4266 High Blood Pressure Medicines
4267 Laxative Abuse
4273 Medicines to Have on Hand
4268 Medicines: Using Them Safely
4269 Nitroglycerin and Other Nitrates
4270 Over-The-Counter Medicines
4271 Sleeping Pills
4272 Smoking and Drug Interaction
4274 Tetanus Vaccine
4275 Tranquilizers
4276 Vasodilators

Men's Health

4600 Enlarged Prostate (Benign Prostatic Hyperplasia)
4601 Erectile Dysfunction (Impotence)
4602 Hair Loss
4603 Infertility
4604 Male Condom
4605 Penile Inflammation
4606 Premature Ejaculation
4607 Prostate Problems
4608 Prostatectomy
4609 Routine Healthcare for Men
4610 Sexual Response in Men
4611 Testicular Self-Examination
4612 Vasectomy

Nutrition and Weight Control

4700 Caffeine in Your Diet
4701 Calcium
4702 Carbohydrates
4703 Dealing with Feelings About Food
4704 Diabetes: Food Management
4705 Dieting and Eating Out
4706 Eating Basics for Children
4707 Eating Healthy Snacks
4708 Exercise to Stay Healthy
4709 Fat in Your Diet
4710 Fat-Free Foods
4711 Fiber in Your Diet
4712 Grains in the Diet
4713 Healthy Weight Gain
4714 Losing Weight
4715 Nutrition for Diabetics: Eating Out
4716 Nutrition for Diabetics: Food Labels
4717 Nutrition for Diabetics: Protein
4718 Nutrition for Diabetics: Use of Alcohol
4719 Obesity
4720 Overcoming Binge Eating
4721 Overweight Child
4722 Overweight or Overfat?
4723 Protein
4724 Reading Food Labels
4725 Salt in the Diet
4726 Sugar in Our Diets
4727 Sugar Substitutes
4728 The Healthy Diet
4729 Usda Food Guide Pyramid
4730 Food Diary Use
4731 Vegetarian Diet
4732 Vitamins
4733 Weight Loss Diets

Preventive Health

4650 Back Pain Prevention: Body Mechanics
4651 Bathroom Safety
4652 Cancer Prevention and Nutrition
4653 Childproofing Your Home
4654 Controlling Cholesterol
4655 Diet for a Healthy Mouth
4656 Drowning Prevention
4657 Exercise to Stay Healthy
4658 Exercises for the Workplace
4659 Personal Health Management
4660 Heart Disease: Prevention
4661 Home Safety Tips
4662 How Noise Affects Hearing
4663 Immunization Schedule: Children
4664 Immunizations: Adults
4665 Lift It Right
4666 Medicines: Using Them Safely
4667 Obesity
4668 Poison Prevention
4669 Preventing Burns and Scalds
4670 Preventing Falls
4671 Protecting Yourself from Cancer
4672 Routine Healthcare for Men
4673 Routine Healthcare for Women
4674 Safety Seats for Children
4675 Stress and Its Effects on the Body
4676 Water: Essential for Good Health

Respiratory Health

4800 Acute Bronchitis
4801 Asthma
4802 Breathing Exercises
4803 Bronchiolitis
4804 Bronchoscopy
4805 Chronic Bronchitis
4806 Chronic Obstructive Pulmonary Disease (COPD)
4807 Collapsed Lung: Injury-Related
4808 Collapsed Lung: Non-Injury-Related
4809 Cough
4810 Emphysema
4811 Pneumonia
4812 Pulmonary Embolism
4813 Pulmonary Function Tests
4814 Shortness of Breath
4815 Sleep Apnea
4816 Sleep Apnea: Infants
4817 Snoring
4818 Thoracentesis
4819 Using Oxygen at Home

Safety and Emergency Preparedness

4900 Animal and Human Bites
4901 Anthrax
4902 Bee Stings
4903 Biological Terrorism Agents
4904 Blisters
4905 Bruises
4906 Cardiopulmonary Resuscitation (CPR)
4907 Chemical Terrorism Agents
4908 Chemical Warning Labels
4909 Choking Prevention
4910 Dehydration
4911 Driving Responsibly
4912 Electrical Shock
4913 Electricity: Preventing Injuries
4914 Eye Symptoms Demanding Immediate Attention
4915 First Aid for First-Degree Burns
4916 First Aid for Second-Degree Burns
4917 First Aid for Third-Degree Burns
4918 Food Poisoning
4919 Food Poisoning: Botulism
4920 Food Poisoning: E. Coli Infection
4921 Food Poisoning: Salmonellosis
4922 Frostbite
4923 Heart Attack: Early Warning Signs
4924 Heat Illness
4925 Home First Aid Supplies
4926 Home Security
4927 Hypothermia
4928 Poisoning
4929 Puncture Wounds
4930 Rape
4931 Rape Prevention
4932 Rice: Rest, Ice, Compression, Elevation
4933 Safety Glasses and Goggles
4934 Scrapes and Scratches
4935 Smallpox Vaccine
4936 Snakebites
4937 Something in Your Eyes
4938 Sore Throat
4939 Spider Bites and Scorpion Stings
4940 Splinters
4941 Sunburn

4942 Tetanus Vaccine
4943 Tick Bites

Skin Health

4850 Acne
4851 Blisters
4852 Boils and Carbuncles
4853 Canker Sores
4854 Cellulitis
4855 Cold Sores (Fever Blisters)
4856 Contact Dermatitis
4857 Dandruff
4858 Eczema
4859 Hives
4860 Impetigo
4861 Itching
4862 Moles
4863 Plantar Warts
4864 Psoriasis
4865 Rosacea
4866 Seborrhea
4867 Sjogren's Syndrome
4868 Skin Infection
4869 Skin Lesions
4870 Skin or Soft Tissue Abscess
4871 Sunburn
4872 Tanning Beds
4873 Warts

Surgery

5000 Anesthesia
5001 Body Contouring
5002 Breast Enlargement (Augmentation Mammoplasty)
5003 Breast Reconstruction
5004 Breast Reduction (Reduction Mammoplasty)
5005 Eyelid Surgery (Blepharoplasty)
5006 Facelifts
5007 Laser Treatment
5008 Liposuction
5009 Nose Reconstruction (Rhinoplasty)
5010 Skin Resurfacing
5011 Tummy Tuck

Symptoms

5050 Abdominal Cramps
5051 Constipation
5052 Cough
5053 Dehydration
5054 Dizziness and Vertigo
5055 Earache
5057 Fever
5058 Heart Palpitations
5059 Heartburn
5060 Insomnia
5061 Irritability
5062 Loss of Appetite
5063 Lymph Nodes: Enlarged
5064 Memory Loss
5065 Nausea and Vomiting
5066 Nervousness
5067 Personality Change
5068 Rectal Bleeding
5069 Shortness of Breath
5070 Skin Lesions
5071 Swallowing Difficulty (Dysphagia)
5072 Tinnitus
5073 Urinary Incontinence
5074 Urination Problems
5075 Wheezing

Tests and Examinations

5100 Angiograms
5101 Arterial Blood Gases
5102 Barium Enema
5103 Barium X-Ray Exam: Esophagus and Stomach
5104 Biopsy
5105 Blood (Serum) Glucose Test
5106 Blood: Iron Test
5107 Bone Marrow Biopsy
5108 Bone Scan
5109 Bronchoscopy
5110 Cholesterol: Lipid Panel Test
5111 Colonoscopy
5112 Colorectal Cancer Screening
5113 Colposcopy of the Vagina and Cervix
5114 Complete Blood Count Test (CBC)
5115 Coronary Angiogram
5116 CT Scanning
5117 Cystoscopy
5118 Diagnostic Laparoscopy
5119 Echocardiogram
5120 Electrocardiogram (ECG or EKG)
5121 Electroencephalogram (EEG)
5122 Electromyogram (EMG)
5123 Endoscopic Retrograde Cholangiopancreatography (ERCP)
5124 Fluoroscopy
5125 Heart Catheterization
5126 Holter Monitors
5127 Magnetic Resonance Imaging (MRI)
5128 Mammograms
5129 Pap Smear (Cervical Smear)
5130 Percutaneous Transhepatic Cholangiography (PTHC)
5131 Sigmoidoscopy
5132 Thyroid Scan
5133 Thyroid-Stimulating Hormone (TSH) Test
5134 Thyroxine (T4) Test
5135 Ultrasound Scanning
5136 Urine Culture
5137 Urine Tests
5138 X-Rays

Urinary and Genital Systems

5350 Acute Kidney Failure (Acute Renal Insufficiency)
5351 Bladder Infection (Cystitis)
5352 Blood in Urine (Hematuria)
5353 Chronic Kidney Failure (Chronic Renal Insufficiency)
5354 Functional Urinary Incontinence
5355 Indwelling Catheter Care
5356 Kegel Exercises for Bladder Control
5357 Kidney Infection (Pyelonephritis)
5358 Kidney Stones
5359 Lithotripsy for Kidney Stones
5360 Overflow Incontinence
5361 Urge Incontinence
5362 Urinary Catheterization
5363 Urinary Incontinence
5364 Urinary Obstruction
5365 Urinary Tract Infection in Men
5366 Urinary Tract Infection in Women

Women's Health

5200 Abdominal Hysterectomy
5201 Abuse and Violence - Adults
5202 Amniocentesis
5203 Atrophic Vaginitis
5204 Bartholin's Gland Cyst
5205 Benign Ovarian Tumor
5206 Birth Control
5207 Birth Control Patch
5208 Birth Control Pills
5209 Bleeding Between Menstrual Periods (Metrorrhagia)
5210 Breast Infection (Mastitis)
5211 Breast Self-Exam
5212 Cervical Cap
5213 Cervical Dysplasia
5214 Cervical Polyps
5215 Cervicitis
5216 Cesarean Section
5217 Choosing a Healthcare Provider for Your Pregnancy
5218 Chorionic Villus Sampling (CVS)
5219 D&C, Diagnostic (Dilation and Curettage)
5220 D&C, Therapeutic (Dilation and Curettage)
5221 Danger Signs in Pregnancy
5222 Depo-Provera
5223 Diabetes in Pregnancy
5224 Diaphragm
5225 Diet During Pregnancy
5226 Diethylstilbestrol (DES)
5227 Drug, Alcohol, and Tobacco Use During Pregnancy
5228 Ectopic Pregnancy
5229 Emergency Birth Control (Morning-After Pill)
5230 Endometrial Biopsy
5231 Endometriosis
5232 Episiotomy
5233 Exercise After Delivery
5234 Exercise During Pregnancy
5235 Female Condom
5236 Female Sterilization
5237 Feminine Hygiene
5238 Fetal Alcohol Syndrome
5239 Fibrocystic Breast Changes
5240 Genetic Screening Before or During Pregnancy
5241 Getting Ready for Pregnancy
5242 Hair Loss in Women
5243 Hot Flashes
5244 Hysteroscopy
5245 Infertility
5246 Intrauterine Device (IUD)
5247 Labor and Delivery
5248 Mammograms
5249 Menopausal Hormone Therapy
5250 Menopause
5251 Menstrual Cramps
5252 Miscarriage
5253 Missed Menstrual Periods (Amenorrhea)
5254 Morning Sickness
5255 Natural Family Planning
5256 Nipple Discharge (Galactorrhea)
5257 Normal Growth of a Baby During Pregnancy
5258 Norplant
5259 Ovarian Cysts
5260 Overcoming Fear of Childbirth
5261 Ovulation Abnormalities
5262 Painful Intercourse
5263 Pelvic Examination
5264 Pelvic Inflammatory Disease
5265 Pelvic Support Problems

5266 Postmenopausal Bleeding
5267 Postpartum Care
5268 Postpartum Complications
5269 Postpartum Depression
5270 Preeclampsia
5271 Pregnancy Tests
5272 Premenstrual Dysphoric Disorder (PMDD)
5273 Premenstrual Syndrome (PMS)
5274 Prenatal Care
5275 Prenatal Tests
5276 Routine Healthcare for Women
5277 Ruptured Membranes
5278 Sex During Pregnancy
5279 Sexual Abstinence
5280 Sexual Response in Women
5281 Skin Conditions During Pregnancy
5282 Smoking During Pregnancy
5283 Spermicides
5284 Stress Incontinence in Women
5285 Tipped Uterus
5286 Toxic Shock Syndrome
5287 Travel When You Are Pregnant
5288 Uterine Fibroids
5289 Vaginal Contraceptive Ring
5290 Vaginal Cysts, Polyps, and Warts
5291 Vaginal Hysterectomy
5292 Vaginal Hysterectomy with Laparoscopy
5293 Vaginitis
5294 Vulvar Dystrophy
5295 Vulvitis
5296 Working During Pregnancy
5297 Yeast Infection (Candidiasis)